



San Diego County Report Card on Children & Families

REPORT CARD 2009



San Diego County Report Card on Children and Families 2009 Edition

Produced in partnership with the County of San Diego Board of Supervisors

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This *Report Card* is available in electronic format at
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EXECUTIVE SUMMARY

The 2009 *San Diego County Report Card on Children and Families* is the continuation of a series of reports that provide a summary of the overall health and well-being of our county's children, youth, and families. The *Report Card* is produced biennially by the Children's Initiative, a nonprofit child advocacy agency in San Diego.

This *Report Card* has been prepared through a public/private partnership that includes the County of San Diego Board of Supervisors, County of San Diego Health and Human Services Agency, The California Endowment, United Way of San Diego County, the San Diego Foundation, and the McCarthy Foundation. The work has been guided by a Leadership Advisory Oversight Committee, comprised of local and national experts in the fields of health, education, child care, child welfare, juvenile justice, and injury and violence prevention. The research and analysis has been overseen by a Scientific Advisory Review Committee, including statisticians, epidemiologists, and program data managers from these same fields of study.

For this *Report Card*, 26 indicators were selected to measure the health and well-being of children and families. The Children's Initiative applied nationally recognized criteria used in results-based accountability projects in order to select indicators. In other words, we examined each indicator and asked: Do we have reliable and consistent data? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome? Using this decision model, we defined a set of indicators that touch on most of the important facets of the lives of children and families.

The one new indicator included in this *San Diego County Report Card* shows trends in receipt of Food Stamps. In addition, new "sub-indicators" and enriched data were added to existing indicators. For example, the poverty indicator also includes information on "near-poor" families living between 100 and 200 percent of poverty. Geographic breakdowns are presented in more detail.

In addition to reporting the current status of the indicators and the trends in the last few years, the *Report Card* for 2009 includes information on national best practices for prevention and intervention, and revised recommendations for action specific to San Diego County. Where available, updates on current county efforts and progress since the last *Report Card* are provided. This information can help to guide policy development, target prevention and intervention efforts, and educate the public.

Summary of Trends

Birth to Three (Infants and Toddlers)

Generally, San Diego County compares favorably to state and national rates, and a consistent positive trend is shown for one out of the four indicators for infants and toddlers. Births to teens remains about the same as in previous years and two trends, early prenatal care and low birthweight, remain of concern.

- **Prenatal care.** The trend is now moving in the wrong direction, away from the national objective.
- **Low-birthweight birth.** The trend is not improving. In San Diego, as elsewhere in the nation, the proportion of babies born at low and very low birthweight is continuing to be a concern.
- **Breastfeeding initiation.** The trend is very gradually improving. San Diego County rates are better than the state average and exceed the national objective.
- **Births to teens.** The trend is not improving. Progress has leveled off since 2003 and the rate increased slightly in 2008. Our rate is slightly better than the state and national averages.

Ages 3 to 6 (Preschool)

For preschool age children, we are doing well on both indicators. The challenge for this age group is to collect more data and better measure their progress toward healthy development and school readiness.

- **Immunization.** The trend is improving in San Diego County and San Diego County is above the state and national rates. We have achieved the national objective for the most recently recommended comprehensive vaccination schedule, but not the goal of 90 percent for each vaccine.
- **Early child care and education.** The trend is steadily improving in San Diego County, in line with state and national trends.

Ages 6 to 12 (School Age)

Among school age children, there is some progress. Yet of major concern is the fact that too many remain overweight or obese. The indicators of school attendance and school achievement, despite progress, remain below optimal levels.

- **Oral health.** While the trend is improving, more than one in eight of our preschool and school age children have never had a dental visit. Our rate is better than the state rate.
- **School attendance.** In school year 2008-09, one quarter of students in grades K-5 attended school less than 95 percent of the time.
- **School achievement.** The trend for achievement in English Language Arts for third graders continues to improve. Our county is above the state average.
- **Obesity.** The trend is not improving. Falling far short of the national objective of 5 percent, 30 percent of fifth and seventh graders are not in the Healthy Fitness Zone and test as overweight or obese.

Ages 13 to 18 (Adolescence)

Indicators of well-being for adolescents show mixed results. School achievement continues to improve. Too many of our youth remain at risk for car crashes, delinquency, substance abuse, arrest, and suicide.

- **School attendance.** In school year 2008-09, one out of every ten students in grades 6 to 12 attended school less than 90 percent of their school days.
- **School achievement.** The trend for achievement in English Language Arts scores among eighth and eleventh graders is improving and remains slightly above state averages. Of concern is that achievement scores drop between eighth and eleventh grade.
- **Substance abuse.** The trend in use of alcohol, cigarettes, and marijuana moved in the wrong direction in 2008-09.
- **Youth suicide.** Between school year 2007-08 and 2008-09 the proportion of ninth and eleventh grade students reporting a suicide attempt increased.
- **Juvenile crime.** The overall trend is improving over time, but this masks differences in types of arrests. Misdemeanor arrest rates continued to decline (improve), while felony arrest rates are worsening.
- **Juvenile probation.** The trend decreased in 2008 after increasing from 2005 through 2007.
- **Youth DUI arrests.** The trend is not improving. After declining through 2005, the number of arrests of 16-20 year olds is increasing. Of concern is the fact that these youth are not of legal drinking age.
- **Motor vehicle crashes involving youth DUI.** The trend is not improving. Despite fluctuations year to year, the rate of alcohol- and drug-related crashes among drivers ages 16-20 is at the same level as in 1996, over a decade ago. Youth continue to use drugs and alcohol and operate motor vehicles, and they had 295 DUI related crashes in 2007.

The majority of our community and family indicators are improving. Of concern is the lack of substantial progress in reducing poverty, crimes against children, and childhood mortality rates. These broad indicators may point to underlying problems in the health and safety net of our community. In addition, in the current economic situation, many San Diego County families are faced with loss of income, lack of health coverage, and not enough food. Economic pressures and unemployment are associated with domestic violence, child abuse and neglect, and crime. The full impact of the recession is not yet known.

- **Poverty.** The percent of children in poverty increased substantially from 2007 to 2008. The child poverty rate of 16.6 percent in 2008 was the highest for San Diego County since 2000. While our child poverty rate is lower than the state and the nation averages, we are not reducing the proportion of our children who live in poverty. An additional group of low-income (with income below 200 percent of the Federal Poverty Level) families with children do not have economic resources to meet basic needs such as housing and food.
- **Food Stamps.** While the number of eligible children receiving Food Stamps is increasing, San Diego County has one of the lowest participation rates among metropolitan areas in the nation.
- **Health coverage.** The trend is improving. By 2007, 93 percent of San Diego's families reported that their children had health coverage. San Diego County was on par with the state average, and well above the national rate.
- **Domestic violence.** The trend is improving. The rate of domestic violence reports is declining in San Diego County, although our rate remains above the state average.
- **Child abuse and neglect.** The trend is improving. The rate of substantiated reports has been declining in recent years, but remains higher than the state average.
- **Child victims of violent crime.** The overall trend is maintaining. The rate dropped slightly in 2008 but not substantially. The number of violent crimes committed against children and youth peaks after school between the hours of 3 pm and 6 pm.
- **Unintentional injury and death.** The trend is improving. The rate of non-fatal unintentional injuries to children has been decreasing, and San Diego County's childhood injury rates dipped below the state average in 2006.
- **Child mortality.** The trend is maintaining. San Diego County's infant mortality rate has been fluctuating somewhat but remains better than state or national averages. The mortality rate for children ages 1-4 shows variation but no substantial improvement. The rate for children ages 5-14 has not improved since 2000, and the rate for youth 15-17 has returned to 2001 levels.

Recommendations for Action

The top ten recommendations for the 2009 *Report Card* focus particularly on prevention and early intervention. San Diego leaders and families have major opportunities to improve the health and well-being of children now and to affect the health of the whole population into the future. Key indicators in this report show many trends, including: the rates for child abuse, domestic violence, and other traumatic events. Other indicators show trends in risky behavior among adolescents. Research tells us these trends are linked.

Conducted through a collaboration between the U.S. Centers for Disease Control and Prevention (CDC) and Kaiser Permanente in San Diego, the Adverse Childhood Experiences (ACE) Study is one of the largest ever conducted about the links between childhood maltreatment and health and well-being in later life. ACE include: childhood physical, emotional, or sexual abuse; witnessing domestic violence; growing up with household substance abuse, mental illness, parental divorce, and/or an incarcerated household member. This important research shows that as the number of adverse events in childhood increases, the risk for adult

health problems increases or multiplies in a strong and graded fashion. Long-term effects include: heart disease, obesity, alcoholism and alcohol abuse, smoking, depression, suicide attempts, illicit drug use, risk for intimate partner violence, and unintended pregnancies. The toll of ACE begins in adolescence, with a strong relationship to early initiation of smoking, sexual activity, illicit drug use, adolescent pregnancies, and suicide attempts. As described by lead researcher, Dr. Vincent Felitti, *“The ACE Study reveals a powerful relationship between our emotional experiences as children and our physical and mental health as adults, as well as the major causes of adult mortality in the United States. It documents the conversion of traumatic emotional experiences in childhood into organic disease later in life. How does this happen, this reverse alchemy, turning the gold of a newborn infant into the lead of a depressed, diseased adult? The Study makes it clear that time does not heal some of the adverse experiences we found so common in the childhoods of a large population of middle-aged, middle class Americans. One does not ‘just get over’ some things, not even fifty years later.”*

We can do more to protect our children and our future by making prevention a priority. We can help protect the potential of each child. Based on what works and what San Diego County has done so far, the top 10 recommendations for local action are presented here. These recommendations were developed in collaboration with local leaders from the public and private sectors. Overall, our top recommendations for action in San Diego County include:

1. **Low Birthweight:** Develop an interconception (between births) care initiative to provide augmented services for 24 months to the highest-risk, lowest-income women who have had a prior low-birthweight birth, miscarriage, or infant death.
2. **Births to Teens:** Increase parent-to-teen communication. Teens who report a good relationship with their parents are less likely to engage in this and other risky behaviors such as truancy, substance abuse, DUI, and crime.
3. **School Attendance:** Monitor attendance at individual school and district levels through monthly reviews. Take prompt action when even small attendance problems are identified.
4. **Obesity:** Encourage eligible families to participate in WIC to improve child nutrition starting at birth. In 2009, the federal government released new guidance, and WIC now provides healthier foods, including fresh fruits and vegetables, and promotes breastfeeding.
5. **Substance Abuse:** Promote youth development activities, after school programs, and early prevention programs.
6. **Juvenile Crime and Probation:** Expand internship programs, job shadowing, and summer and after school employment opportunities for middle and high school youth. Evaluate community needs and gaps in services and expand successful prevention programs to match community needs.
7. **Driving Under the Influence (DUI):** Work toward passage of state legislation to restore driver education in schools.
8. **Poverty:** Provide outreach to assure that families who have become unemployed or underemployed have knowledge and access to: apply for public assistance such as unemployment, income, health, and housing benefits; take advantage of job training and educational opportunities; and use EITC, IDA, and ITA to improve their economic status.
9. **Child Abuse and Neglect:** Expand intensive home visiting for vulnerable families. This strategy can also help to reduce repeat teen births, increase use of preventive child health services, optimize school readiness, and improve parenting skills overall.
10. **Childhood Injury and Mortality:** Continue and expand efforts that improve child safety, including gun safety programs, “back-to-sleep” campaigns, and enforcement of existing child vehicle restraint laws (e.g., child car seats) and helmet laws.

BACKGROUND

“Report cards” are valuable tools used to measure and monitor the well-being of populations. This *Report Card* monitors how well San Diego County’s children and youth and their families are doing in terms of health, education, safety, and economic security. Report cards are designed to raise community awareness about current issues and trends relating to the health and well-being of children, youth, and families. These reports can point to troublesome trends or positive results, and make recommendations for change or continued support in policies and programs.

Results (or outcomes) are conditions of well-being for children, adults, families, or communities. They are what we hope to achieve as a community: including children who are healthy, ready for and succeeding in school, avoiding risky behaviors, and staying out of harm’s way. For example, we aim for families to have economic security and safe homes and neighborhoods.

Report cards include indicators that serve as benchmark measures to monitor our progress toward the desired results. They tell us how we are doing, whether or not we are moving in the right direction, and if trends point to problems in our safety net for children and youth. For this *San Diego Report Card on Children and Families*, 26 indicators were selected to measure the health and well-being of infants and toddlers, preschoolers, school age children, and adolescents, as well as status across age groups.

While sound policies and the efficient allocation of resources are important, other factors influence our children’s outcomes. Our public and private programs work to improve the health and well-being of the people they serve, but getting good results often depends on effective implementation of integrated strategies across systems and agencies. While there are no single shot or silver bullet strategies, research tells us much about what strategies have proven effective to improving the conditions of children and families. For each indicator, we have included an up-to-date list of what works based on national research and best practices from across the United States. Finally, this *Report Card* offers San Diego-specific recommendations, based on what works, in order to improve results for our children and their families.

San Diego Report Card History

Beginning in 1997-98, the San Diego County Health and Human Services Agency (HHSA) undertook the development and publication of the *Report Card on San Diego County Child and Family Health and Well-Being*. For seven years, this report on trends was funded primarily by and published by HHSA. The last edition of that *Report Card* was issued for year 2005. As county services were reconfigured, the Board of Supervisors searched for an alternative way to produce and publish this important document. The Board of Supervisors partnered with the Children’s Initiative, a local nonprofit agency which serves as an advocate and custodian for effective policies, programs, and services that support the health and well-being of children, youth, and families, to study the characteristics of effective and sustainable report cards across the country.

The Children’s Initiative commissioned the San Diego State University (SDSU) School of Business to study best practices in developing and sustaining community report cards from across the country. This analysis found that report cards are best used as part of a process for raising community awareness and working toward improved child and family policies and advocacy strategies, not just an exercise in reporting data or trends. It also concluded that community engagement is critical to the success and sustainability of these efforts, using input from a broad and diverse array of stakeholders in selection of indicators and in making recommendations. Sustainable report cards used blended, public-private funding. It is equally essential to link what is learned to a process for program and policy change, through which community members and

policy makers mobilize together to implement strategies to increase public investment for children, youth, and families.

Given this larger perspective on the role and strategy for report cards, in January 2006, the San Diego County Board of Supervisors approved the transfer of ownership and responsibility for the county *Report Card* to the Children's Initiative. The first edition of the new *Report Card* was published in January 2008.

The Report Card Development Process

In 2006, the Children's Initiative, building upon previous report cards, introduced significant changes reflecting best practice from around the country. The Children's Initiative involved a broad array of stakeholders, updated and added new indicators, reported on effective practices, and provided recommendations. Public and private funders came together to support this revised approach. For the 2009 *Report Card* funders included: the County of San Diego Board of Supervisors, County of San Diego HHSA, The California Endowment, United Way of San Diego County, the San Diego Foundation, and the McCarthy Foundation.

This *Report Card* was also developed as a public-private partnership with a broad array of stakeholders. It reflects the advice and expertise of: public agency and government officials; subject matter experts in education, health, and other fields; providers and community-based organizations; and parents and youth. Both a Leadership Advisory Oversight Committee and Scientific Advisory Review Committee were convened to guide the entire process. The Children's Initiative used input from a diverse group of subject matter experts and community representatives (including families) during the process of selecting indicators, securing reliable data, identification of best practices, and developing specific San Diego recommendations.

Local and national experts were involved in selecting indicators to assure that the indicators used in this *Report Card* are both valid measures and meaningful to the community. The Children's Initiative used widely recognized principles and criteria in the indicator selection process. The staff and advisory committees examined each indicator to determine which indicators had the strongest data, offered the best communication power, and reflected most broadly on a given topic such as crime or mortality. The committees examined each indicator and asked: Do we have reliable and consistent data? Does the indicator communicate to diverse audiences (e.g., families, communities, policy makers)? Does the indicator say something of importance about the desired outcome?

In addition to reporting the current status of the indicators and the trends in the last few years, the 2009 *Report Card* provides two important types of information: national best practices for prevention and intervention, and recommendations for action specific to San Diego County. Best practices were identified from respected sources such as professional journal publications, universities, government agencies, and other research organizations. Recommendations for action in this *Report Card* were designed by the Report Card Committee members, subject matter experts, and national consultants. Due to the "snapshot" nature of the *Report Card*, these sections offer examples and are not intended to be exhaustive or complete lists of possibilities.

Understanding This Report Card

To use this *Report Card* most effectively, it is helpful to understand how the data are presented. The most recent data available at the time of production are generally used. Depending on the type and source of information, the most recent data available may be for 2006, 2007, or 2008.

Trend charts are presented to illustrate the status of an indicator over time. No tests have been done to determine the statistical significance of time-trend changes; we are only observing whether the trends are

improving, maintaining, or worsening. It is important to note that a change in a specific rate for one year may be the result of a temporary environmental change, a change in data sample, or some other extraneous influence, and may not represent a true change in the trend. When possible, comparison data are presented to assist in understanding how our county is doing compared to California or United States averages, as well as to federal Healthy People 2010 objectives set by the U.S. Department of Health and Human Services.

Data are presented in percentages and rates, reflecting the norms and standards for a particular data source. Using these standardized measures makes it easier and more accurate to look at trends or make comparisons. A percentage is the most easily understood comparison and is used whenever appropriate. Rates per 1,000, 10,000, or 100,000 people are used when the incidence of a condition is low.

Most charts are shown for calendar years. Three-year averages are used when the population referred to is small, or when the data are likely to have year-to-year fluctuations that do not indicate actual underlying change in the indicator. For education data, the trends are shown in school years (e.g., 2008-09).

Most charts show data on a scale of 1 to 100, 1 to 50, or 1 to 25, depending on the level of the trend. For some, however, the scale has been modified to better show the variation year-to-year. When that occurs, the chart is marked with the words “note scale.”

In a few instances, numbers instead of percentages or rates are used. This is done when it would be impossible to calculate the denominator — the number of individuals who might be subject to a condition. So, for example, we report the number of youth DUI arrests and the number of individuals receiving Food Stamps.

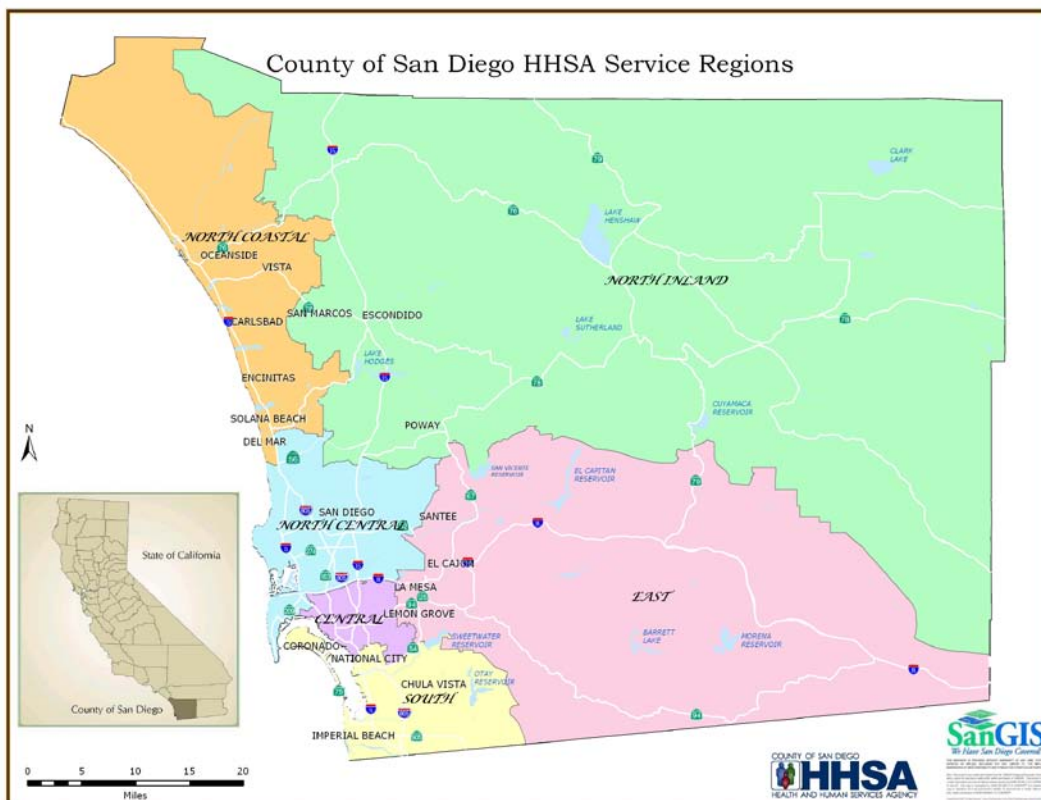
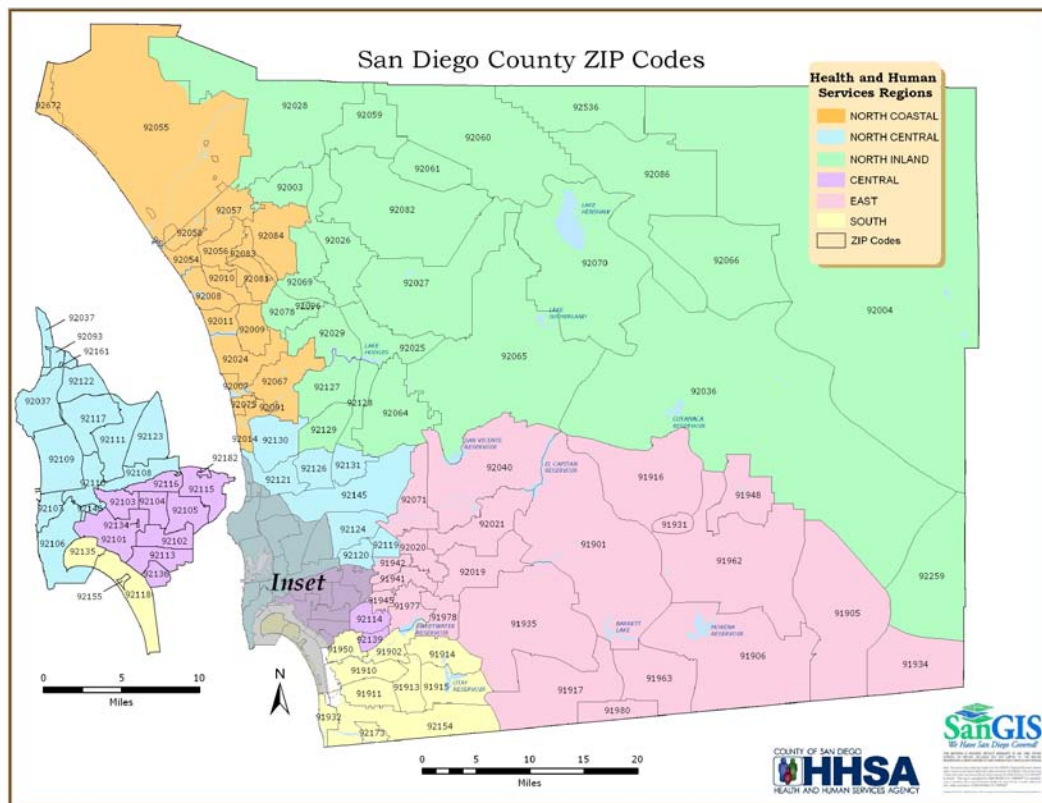
Notes on Geographic and Racial/Ethnic Data

San Diego is a large county, stretching 65 miles from north to south, and 86 miles from east to west, covering 4,261 square miles, slightly smaller than the state of Connecticut. It borders Orange and Riverside Counties to the north, the agricultural communities of Imperial County to the east, the Pacific Ocean to the west, and the State of Baja California, Mexico, to the south. With an elevation that goes from sea level to 6,500 feet, our county includes beaches, deserts, and mountains. Our communities incorporate urban, suburban, and rural neighborhoods. San Diego County is comprised of 18 incorporated cities and 17 unincorporated communities and even these are divided into locally identified communities and neighborhoods. The County of San Diego HHSA prepared geocoded maps for this *Report Card* that illustrate the occurrence of selected indicators according to more precise and easily understood community boundaries (e.g., zip code areas).

The county's total population in 2008 is estimated at over 3 million, and it is now the second most populous county in the state, after Los Angeles County. Children under age 18 represent 25 percent of our population, and those under 5 represent about 8 percent of San Diego County residents.

The San Diego Association of Governments (SANDAG) reports that the region's population under 18 is distributed throughout urban, suburban, and rural areas, notably in inland communities. Areas with the highest concentrations — with more than one-third of the population being children under age 18 — are in El Cajon, Escondido, and Oceanside. In the part of Tierrasanta that contains off-base, military family housing, half of the population is under age 18. The areas with lower proportions of child residents tend to be found adjacent to the coastline such as Del Mar, Coronado, and Solana Beach.

San Diego County is an ethnically diverse community. The overall population consists of: 51 percent non-Hispanic white; 31 percent Hispanic; 6 percent African American; 11 percent Asian, Hawaiian; or Other Pacific Islander; and 1 percent Native American or Alaskan Native. The population of children is similarly distributed, with slightly more having Hispanic origins. San Diego County has 18 American Indian reservations, more than any other county in the United States, representing four tribal groups. Data on race and ethnicity are not uniformly available. Where appropriate, tables with racial/ethnic variations are included.



REPORT CARD SUMMARY TABLE

County, State, and National Comparisons

Key to table symbols.

▲ Trend is improving.

● Trend is maintaining.

▼ Trend is not improving.











Indicator	Trend	San Diego County	California	United States
Birth to Age 3 (Infants and Toddlers)				
Percent of mothers receiving early prenatal care	▼	81.3	82.4	83.2 ²
Percent of infants born at low birthweight	▼	6.6	6.8	8.2 ¹
Percent of mothers who initiate breastfeeding of newborn in hospital	▲	90.7 ¹	86.6 ¹	NA
Birthrate per 1,000 teens ages 15-17 years	●	18.9	19.1	22.2 ¹
Ages 3-6 (Preschool)				
Percent of young children (ages 19-36 months) who completed the basic immunization series	▲	85.3 ²	78.7	76.1
Percent of children ages 3-4 enrolled in early care and education	▲	54.8	50.7	49.1
Ages 6-12 (School Age)				
Percent of children ages 2-11 who have never visited a dentist	▲	11.5 ¹	13.7 ¹	NA
Percent of elementary school (K-5) students who did not attend school at least 95 percent of school days	●	25.0	NA	NA

All numbers are for year 2008 or school year 2008-09 unless otherwise noted.

¹ numbers from 2007 and school year 2007-08

² numbers from 2006

³ aggregate data for school years 2006-07 and 2007-08













Indicator	Trend	San Diego County	California	United States
Percent of students in grade 3 scoring proficient or advanced on the English Language Arts achievement test		51.0	44.0	NA
Percent of students not in the Healthy Fitness Zone (overweight or obese)				
Grade 5		28.7 ¹	31.6 ¹	NA
Grade 7		29.9 ¹	31.6 ¹	NA
Grade 9		30.6 ¹	30.3 ¹	NA
Ages 13-18 (Adolescents)				
Percent of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days		10.0	NA	NA
Percent of students scoring proficient or advanced on the English Language Arts achievement test				
Grade 8		54.0	48.0	NA
Grade 11		44.0	40.0	NA
Percent of students who report using cigarettes in past 30 days				
Grade 7		5.6	5.0 ³	NA
Grade 9		11.4	9.0 ³	14.3 ¹
Grade 11		15.3	14.0 ³	21.6 ¹

All numbers are for year 2008 or school year 2008-09 unless otherwise noted.

¹ numbers from 2007 and school year 2007-08

² numbers from 2006

³ aggregate data for school years 2006-07 and 2007-08















Indicator	Trend	San Diego County	California	United States
Percent of students who report using alcohol in past 30 days				
Grade 7		14.3	14.0 ³	NA
Grade 9		25.7	26.0 ³	35.7 ¹
Grade 11		36.0	37.0 ³	49.0 ¹
Percent of students who report using marijuana in past 30 days				
Grade 7		5.7	5.0 ³	NA
Grade 9		14.0	12.0 ³	14.7 ¹
Grade 11		19.0	18.0 ³	21.4 ¹
Percent of male students who report they attempted suicide in previous 12 months				
Grade 9		11.2	NA	5.3 ¹
Grade 11		7.3	NA	3.7 ¹
Percent of female students who report they attempted suicide in previous 12 months				
Grade 9		13.0	NA	10.5 ¹
Grade 11		9.2	NA	7.8 ¹
Number of arrests for misdemeanor and felony crimes among youth ages 10-17		14,218 ¹	NA	NA
Number of sustained petitions (true finds) in Juvenile Court among youth ages 10-17		5,632	NA	NA

All numbers are for year 2008 or school year 2008-09 unless otherwise noted.

¹ numbers from 2007 and school year 2007-08

² numbers from 2006

³ aggregate data for school years 2006-07 and 2007-08

Indicator	Trend	San Diego County	California	United States
Number of DUI arrests among youth under age 18		153 ¹	1,635 ¹	NA
Rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population		122.7 ¹	NA	NA
Community and Family (Cross Age)				
Percent of children ages 0-17 living in poverty		14.9 ¹	17.3 ¹	18.0 ¹
Number of households receiving Food Stamps		120,669	NA	NA
Percent of children ages 0-17 who are without health coverage		4.7 ¹	5.7 ¹	11.0 ¹
Rate of domestic violence reports per 1,000 households		15.2	13.2	NA
Rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17		12.0	9.7	NA
Rate of violent crime victimization per 10,000 children or youth				
Ages 0-11		5.1	NA	NA
Ages 12-17		66.8	NA	NA
Rate of unintentional injuries per 100,000 children ages 0-18		202.6 ²	221.0 ²	NA
Infant mortality rate per 1,000 live births		5.1 ¹	5.2 ¹	6.5 ¹
Rate of mortality per 1,000 children				
Ages 1-4		20.7 ¹	22.8 ¹	28.6 ¹
Ages 5-14		11.7 ¹	12.0 ¹	15.2 ¹
Ages 15-17		31.1 ¹	NA	NA

All numbers are for year 2008 or school year 2008-09 unless otherwise noted.

¹ numbers from 2007 and school year 2007-08

² numbers from 2006

³ aggregate data for school years 2006-07 and 2007-08



“When we talk about giving every child a healthy start in life...we mean safe pregnancies, which begin even before conception with Folic Acid intake and other forms of good nutrition...and early prenatal care.” David E. Satcher, former U.S. Surgeon General

Birth to Age 3 (Infants and Toddlers): EARLY PRENATAL CARE

What is the indicator?

The percent of mothers receiving early prenatal care.

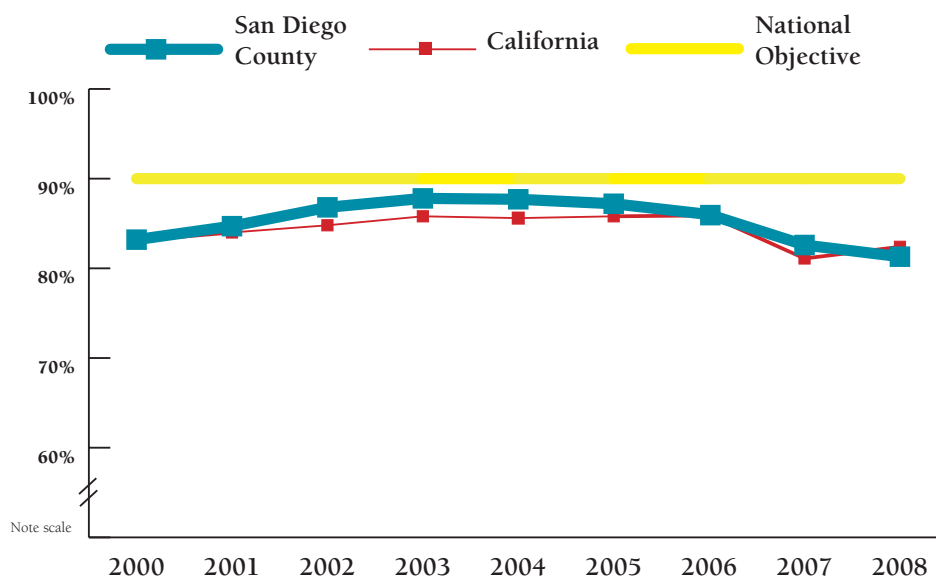
This indicator — the percent of mothers receiving early prenatal care — reflects the percent of women who receive prenatal care beginning in the first three months (referred to as the first trimester) of pregnancy. A related measure is “adequate” prenatal care, which accounts for both the timing of entry into care (early, late, etc.) and the number of visits. Prenatal care information is recorded on the birth certificate and reported as part of local, state, and federal vital statistics.

Why is this important?

Prenatal care from a qualified health professional is recommended to monitor the health of a woman and her baby during pregnancy. Optimal care includes medical services and health education. Beginning care early, during the first three months of pregnancy, gives time to monitor and treat detected problems. Inadequate prenatal care (starting late or too few visits) is associated with premature birth, low birthweight, and increased risk of mortality for the fetus, infant, and mother. The Centers for Disease Control and Prevention (CDC) recommends starting care even before conception (preconception care) to reduce health risks to both mother and baby.

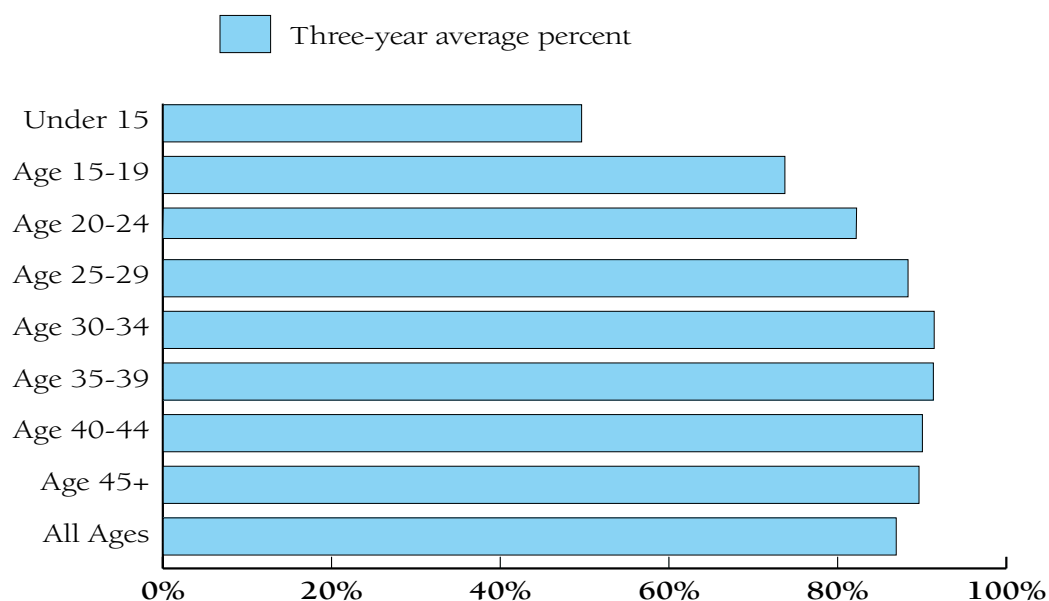
How are we doing?

Percent of Mothers Receiving Early Prenatal Care, San Diego County and California Compared to National Objective, 2000-2008



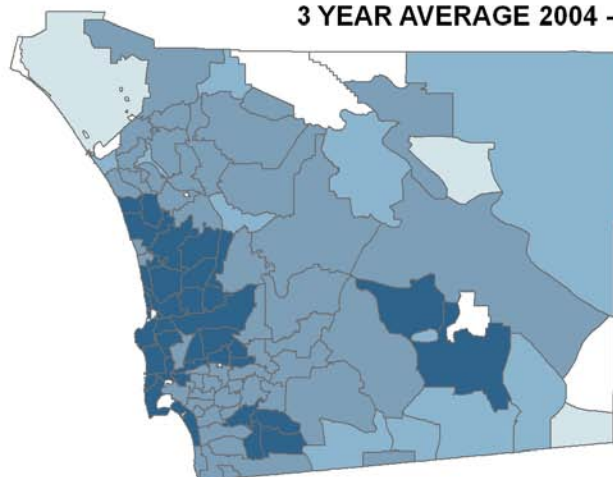
San Diego is moving in the wrong direction and more work needs to be done. Our rate is lower than the state average, and we are moving away from the national objective.

Percent of Mothers Receiving Early Prenatal Care, By Age, San Diego County, Three-year Average 2004-06



San Diego County's youngest mothers are less likely than older women to begin prenatal care early. This is particularly true among pregnant teens, but even those ages 20-24 fare less well.

PERCENT OF BIRTHS WHERE MOTHER RECEIVED EARLY PRENATAL CARE: 3 YEAR AVERAGE 2004 - 06



Early Prenatal Care, %

- Insufficient or no data
- < 60%
- 60% - 80%
- 80% - 90%
- > 90%

Overall County %	86.9%
California State %	86.5%

NOTE: Data from State of California, Dept. of Public Health, Center for Health Statistics, Birth Statistical Master File. Prepared by County of San Diego, HHSA, Maternal, Child and Family Health Services. Data is for births in 2004-2006 with known prenatal care start time. This is a measure of prenatal care initiation, not frequency of care. Data with missing or invalid zip code are excluded from the map (<1%).

The areas with the best rates for early prenatal care utilization include North Central San Diego, Chula Vista, Descanso, and Pine Valley.

What strategies can make a difference?

There are many factors that can affect whether or not a pregnant woman receives early prenatal care. An Institute of Medicine report identified four categories of barriers. First, financial barriers due to lack of health coverage still affect many near poor, working families. Second, the context of care has a significant impact (e.g., negative attitudes of health care providers, long waits after arriving for appointments, lack of cultural competence). Third, the accessibility of care (e.g., transportation, difficulties obtaining an appointment, inconvenient hours) makes a difference. Last, but not least, personal attitudes and behaviors (e.g., ambivalence about the pregnancy, lack of understanding about the importance of prenatal care) are barriers to timely prenatal care. What works best is high quality, accessible care, appropriate to address a woman's medical and psychosocial needs.

The following strategies have been used across the country to increase use of prenatal care:

- Removing financial barriers through expanded eligibility for health coverage, typically using public subsidies to make insurance affordable (e.g., Medi-Cal, Healthy Families).
- Improving the context of care by making prenatal clinics more user friendly (e.g., accessible by public transportation, flexible service hours).
- Using approaches such as “Centering Pregnancy,” a program developed in California, which uses group care sessions to reduce costs while providing more care.
- Assuring comprehensive care (e.g., the California Comprehensive Perinatal Care Services package), which incorporates education and counseling.
- Using home visiting programs that provide evidence-based services throughout pregnancy, particularly for high-risk and first-time mothers.
- Using outreach to encourage use of early and continuous care.
- Offering transportation assistance such as vouchers for public transportation or taxis.
- Providing prenatal services that are culturally and linguistically appropriate.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with community clinics, hospitals, health care providers, United Way of San Diego County, First 5 San Diego, faith communities, HHSA-Public Health, March of Dimes, Metropolitan Transit System, municipalities, and California Health and Human Services Agency to:

1. Expand the availability of transportation vouchers in low-income communities to assist pregnant women in reaching community clinics and other prenatal care providers.
2. Assist community clinics in adopting the “Centering Pregnancy” (group prenatal care and education) approach in community clinics, including culturally competent practices.
3. Expand use of intensive home visiting for high-risk pregnant women.



“One of the most important steps you can take to have a healthy pregnancy is to see your health care provider before you conceive.” March of Dimes

Birth to Age 3 (Infants and Toddlers): **LOW BIRTHWEIGHT**

What is the indicator?

The percent of infants born at low birthweight.

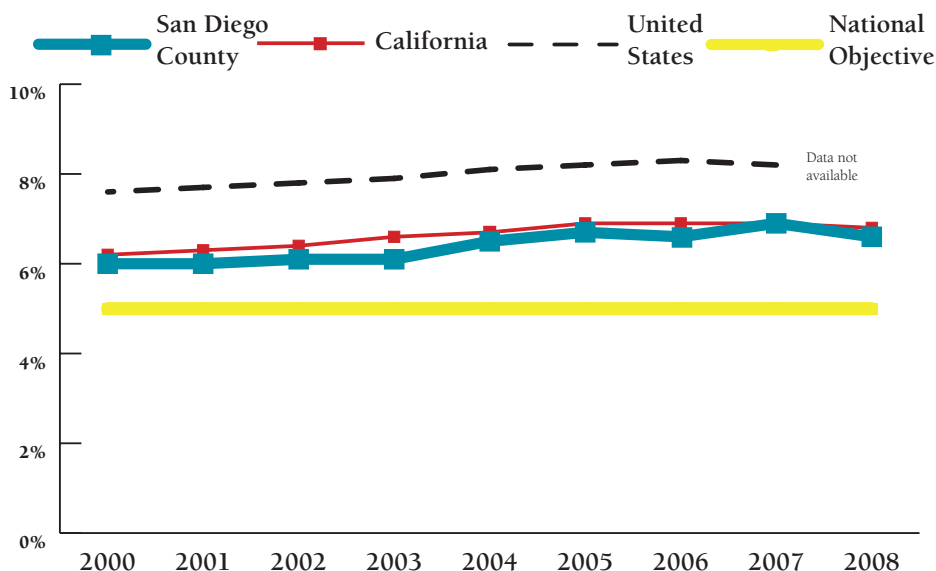
This indicator — the percent of infants born at low birthweight — is defined as weighing less than 2500 grams (5.5 lbs), and very low birthweight is defined as weighing less than 1500 grams (3.3 lbs) at birth. Both are included in this measure. These data are recorded on birth certificates and reported as part of local, state, and federal vital statistics.

Why is this important?

Babies born at low birthweight face 20 times the risk of dying in their first year of life. Premature birth (prior to 37 weeks gestation) is a primary factor in the rate of low birthweight, and together low birthweight and prematurity are the leading cause of infant mortality. With neonatal intensive care, many babies born too soon and too small now survive, but risks to health and development continue. Low birthweight can lead to problems such as poor lung development, cerebral palsy, and learning disabilities. Recent studies suggest that people born at low birthweight face higher risk for adult chronic health conditions, as well as having low-birthweight babies if they have children.

How are we doing?

Percent of Infants Born at Low Birthweight, San Diego County, California, and United States Compared to National Objective, 2000-2008



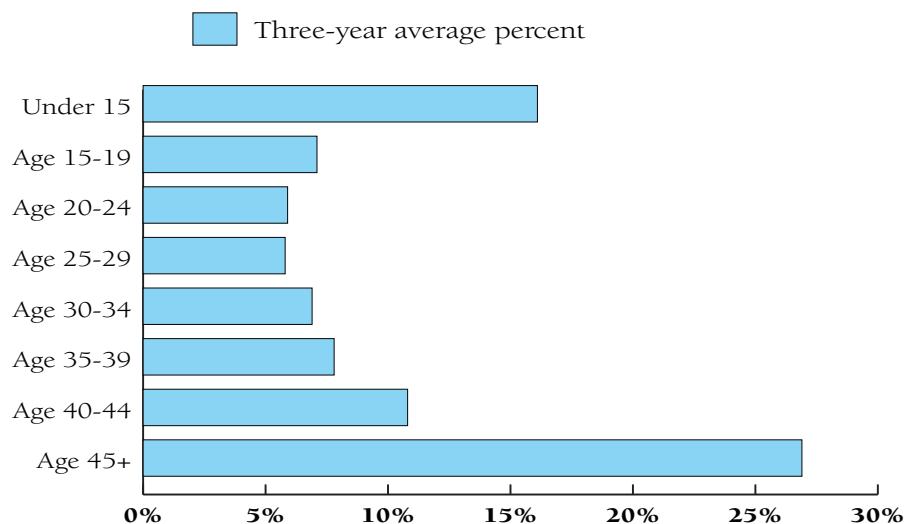
The overall trend in San Diego is not improving. As elsewhere in the nation, the proportion of babies born at low and very low birthweight is gradually increasing. Our rate is comparable to the state rate.

**Percent of Infants Born at Low Birthweight,
By Race/Ethnicity, San Diego County,
Three-year Average 2005-07**

Race/ethnicity	Percent
African American	11.6
Asian total	7.9
Pacific Islander	7.4
Native American	6.3
Hispanic	5.9
White	6.4

Consistent with national trends, African-American women in San Diego County experience the highest rate of low-birthweight birth.

**Percent of Infants Born at Low Birthweight,
By Age, San Diego County, Three-year Average 2005-07**



In San Diego, as in most communities, teen mothers and mothers over 40 are more likely to have low-birthweight babies.

What strategies can make a difference?

While the precise causes of low birthweight and prematurity continue to be studied, we can identify and reduce some of the contributing risks. Smoking and poor nutrition are two of the most widely known factors associated with low birthweight. Other biomedical risks include certain infections, periodontal disease, and diabetes. Very young teen mothers (under age 15) who may not be physically mature enough for childbearing and women who have multiple births (twins, triplets, etc.) are more likely to have babies born at low birthweight. Women who receive late or no prenatal care also are more at risk, because of untreated conditions. Since the most reliable predictor for a low-birthweight birth is a prior low-birthweight birth, experts recommend intervening between pregnancies to reduce risks.

The following strategies have been used across the country to reduce low-birthweight births:

- Getting women into prenatal care early and often to screen for infections, complications, and other risk factors.
- Increasing awareness of risks for pregnancy complications such as use of alcohol or drugs, smoking, certain prescription drugs, sexually transmitted diseases, hypertension, and diabetes.
- Reducing smoking and exposure to secondhand smoke before and during pregnancy.
- Reducing stress and exposure to violence.
- Promoting proper nutrition and healthy weight before and during pregnancy.
- Reducing pregnancy among younger teens.
- Using intensive home visiting to high-risk pregnant women.
- Avoiding multiple births that result from assistive reproductive technology.
- Promoting health and reducing risks before and between pregnancies (known as preconception and interconception care).

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with health providers — including physicians, nurse midwives, community clinics, and hospitals — March of Dimes, HHSA-Maternal, Child and Family Health Services, WIC, Red Cross, San Diego State University, First 5 San Diego, United Way of San Diego County, community-based organization, and faith communities to:

1. Develop an interconception (between births) care initiative to provide augmented services for 24 months to the highest-risk, lowest-income women who have had a prior low-birthweight birth, miscarriage, or infant death.
2. Expand intensive home visiting to high-risk pregnant women.
3. Train providers to use evidence-based smoking cessation programs, such as the National Cancer Institute's "4 A's" with pregnant women.



“As a mother, one of the best things that only you can do for your baby is to breastfeed. Breastfeeding is more than a lifestyle choice — it is an important health choice.” U.S.

Department of Health and Human Services, Office of Women’s Health

Birth to Age 3 (Infants and Toddlers): **BREASTFEEDING**

What is the indicator?

The percent of mothers who initiate breastfeeding of newborn in hospital.

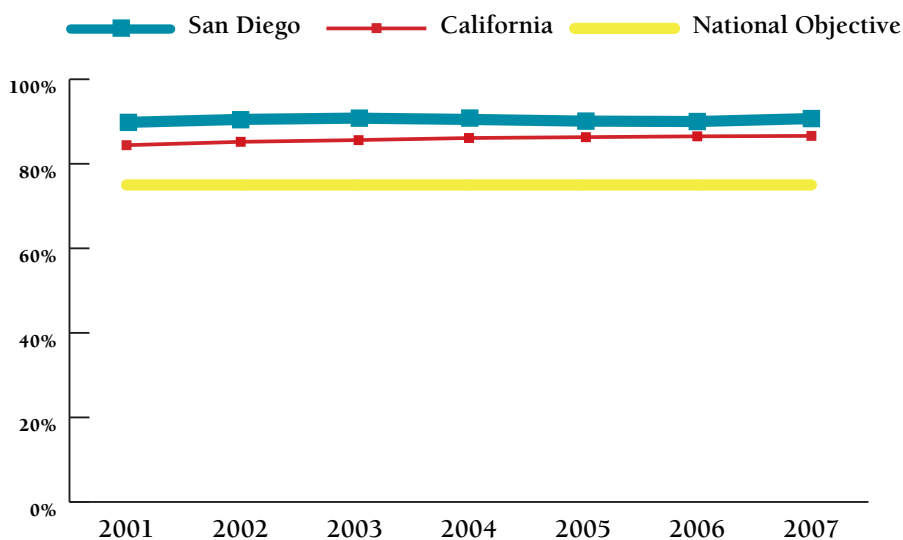
This indicator — the percent of mothers who initiate breastfeeding of newborn in hospital — estimates what proportion of infants receive breast milk. The data are collected on newborn screening forms and reported by the California Department of Health Services, including virtually all births in California (military hospitals and home births are excluded). National recommendations call for 6 to 12 months of breastfeeding, but data on continuation rates are available for only a small segment of the population.

Why is this important?

Breastfeeding is among the most effective and cost-effective preventive health practices. For children, it enhances immunity to disease and decreases the rate and severity of diarrhea, respiratory infections, and ear infections. Breastfeeding is correlated with improved brain development and is associated with reduced risk of Sudden Infant Death Syndrome (SIDS) and childhood obesity. Breastfeeding also may reduce lifelong risks for chronic health problems. Benefits to the mother include reduced incidence of breast cancer, quicker recovery after pregnancy, and reduced loss of bone density. Lastly, breastfeeding costs far less than formula and lactating mothers miss less work due to child illness.

How are we doing?

**Percent of Mothers Who Initiate Breastfeeding of Newborn in Hospital,
San Diego County and California Compared to National Objective, 2001-2007**



The trend for breastfeeding initiation is gradually improving. The San Diego County rate continues to be better than the state rate. We have exceeded the national objective.

What strategies can make a difference?

To improve maternal and child health, both the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics recommend exclusive breastfeeding for the first six months and support breastfeeding till one year or even longer if desired. Multiple factors influence the choice and ability to breastfeed. Factors that inhibit breastfeeding include: the belief that breastfeeding is difficult, challenges when mothers return to work, formula marketing, lack of education and support, and some medical conditions. The CDC 2009 Breastfeeding Report Card identifies key processes, including: professional support, mother-to-mother support, state legislation, and public infrastructure (e.g., public facilities). Studies do not show that raising awareness alone will increase breastfeeding rates. The U.S. Preventive Services Task Force found evidence that ongoing professional support to mothers can significantly increase the proportion who continue breastfeeding for up to six months.

The following strategies have been used across the country to increase breastfeeding:

- Assuring that all birthing hospitals and centers encourage breastfeeding through programs such as “Baby-Friendly Hospitals,” which support mothers in learning how to breastfeed and promote exclusive use of breast milk.
- Providing ongoing culturally informed education for mothers and health care providers.
- Offering workplace breastfeeding support (e.g., breaks/flexible schedules, designated areas for milk expression, and options to safely store breast milk).
- Limiting the marketing of breast milk substitutes (i.e., formula).
- Enacting laws that protect breastfeeding in public and require workplace supports.
- Offering breastfeeding support and lactation education, resources, and warmlines/help desks; particularly from trained and experienced lactation consultants, home visitors, and/or nurses.
- Using the Business Case for Breastfeeding national “toolkit,” prepared by the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.
- Encouraging eligible families to use the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, which now offers additional incentives for breastfeeding.

How can we improve the trend in San Diego County?

In San Diego County, two hospitals have achieved the “Baby-Friendly” certification: Scripps Memorial in Encinitas and UCSD Medical Center in San Diego. Most hospitals without certification follow only some of the best practices. California has adopted laws that protect the right to breastfeed in public and that require some support for lactation in the workplace.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with health providers — including physicians, nurse midwives, community clinics, and hospitals — local Chambers of Commerce, businesses and business associations, San Diego Workforce Partnership, WIC, First 5 San Diego, HHSA-Public Health, Childhood Obesity Initiative, and health plans to:

1. Provide the national toolkit and a recognition program to encourage businesses to promote workplace practices that support breastfeeding continuation, particularly where young and low-income women are employed.
2. Expand Baby-Friendly Hospital policies to all birthing hospitals and facilities throughout San Diego County.
3. Increase the availability of lactation support to all first-time mothers, both at home and the workplace.



“When it comes to teens’ decisions about sex, parents underestimate their own influence and overestimate the influence of others.” National Campaign to Prevent Teen Pregnancy

Birth to Age 3 (Infants and Toddlers):

BIRTHS TO TEENS

What is the indicator?

The birth rate per 1,000 teens ages 15-17 years.

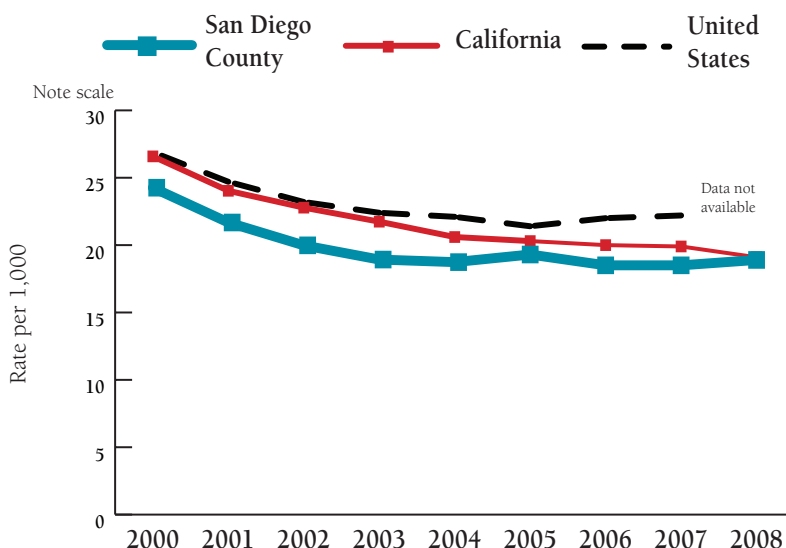
This indicator — the birth rate per 1,000 teens ages 15-17 years — monitors trends in teen births for teens ages 15-17. Reliable data are available annually from birth certificates and reported as part of local, state, and federal vital statistics. It is not possible to get reliable data on the number of teens who become pregnant or are sexually active. This indicator is also a better gauge of the number of teens who will be parenting.

Why is this important?

The United States has the highest teen pregnancy rate of any industrialized country. Teens are generally unprepared for the responsibility of pregnancy and parenting. They are less likely to obtain early prenatal care and proper nutrition, and more likely to continue unhealthy behaviors, placing the baby at risk for future developmental and health problems. Teen parents are less likely to complete their education, and thus are at greater risk of earning below poverty incomes. Their babies are at greater risk for neglect and abuse. Teen parenthood places two generations at risk.

How are we doing?

**Birth Rate per 1,000 Teens Ages 15-17,
San Diego County, California, and United States, 2000-2008**



The trend is not improving. Although rates are lower than in 2000, most of this decline occurred between 1997 and 2002. Progress has leveled off in the last 5 years. Between 2007 and 2008, the rate increased only from 18.5 to 18.9 per 1,000.

What strategies can make a difference?

There is no single preventive intervention that is effective across the complex array of factors that underly teen pregnancy. The Centers for Disease Control and Prevention (CDC) and the National Campaign to Prevent Teen and Unplanned Pregnancy have studied factors related to the trends. Best practices must be broad based and across systems that include: comprehensive education, early prevention services and activities, age appropriate interventions, and teen and family support.

The following strategies have been used across the country to decrease teen births:

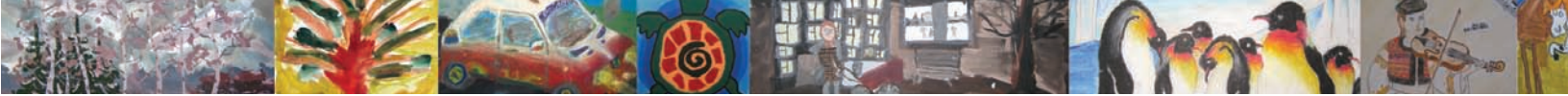
- Promoting positive family involvement, including supervision, goals, and expectations. Teens who report a good relationship with their parents are less likely to engage in this and other risky behaviors.
- Involving males in discussion and education; one of the most significant factors in the reduction of teen pregnancy is increased education and information for males.
- Teaching comprehensive life skills and reproductive health education in schools through use of effective curriculum-based sex and STD/HIV education programs.
- Providing after-school programs and activities to engage teens in the critical hours. Youth who attend after-school programs and/or engage in other after-school activities (e.g., sports, employment, art, music) are less likely to engage in risky behaviors such as sexual activity and more likely to adopt positive future life plans.
- Providing programs to engage youth during the summer and school holidays.
- Prioritizing groups at special risk and involving community members to increase cultural relevance.
- Encouraging teen parents to continue in school to help reduce subsequent pregnancies.
- Providing access to comprehensive and confidential reproductive health services, including education about contraceptive methods and family planning services.

How can we improve the trend in San Diego County?

Efforts to prevent teen pregnancies are underway across the county. The San Diego Adolescent Pregnancy and Parenting Program (SANDAPP), in the San Diego Unified School District, offers case management and counseling services to pregnant and parenting teens. They served 1,017 teens in school year 2008-09. While the national rate of repeat teen pregnancies is 17.5 percent, the rate for those served by SANDAPP is only 3 percent.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with parents and parent organizations, schools and school districts, teen pregnancy prevention programs, HHSA-Public Health, First 5 San Diego, SANDAPP, health providers, community-based organizations, and California Health and Human Services Agency to:

1. Increase parent-to-teen communication using effective programs and strategies such as Plain Talk/Hablando Claro from the Annie E. Casey Foundation and scripts from the National Campaign to Prevent Teen and Unplanned Pregnancy .
2. Expand health services that counsel teens regarding abstinence and contraception to help teens to make safe and healthy choices.
3. Expand pregnancy prevention programs such as the SANDAPP offering opportunities for youth to talk with peer educators and health educators in middle school and high school.



“Few interventions in public health or preventive medicine can compare with the impact of the childhood immunization program.” Centers for Disease Control and Prevention

Ages 3–6 (Preschool): IMMUNIZATION

What is the indicator?

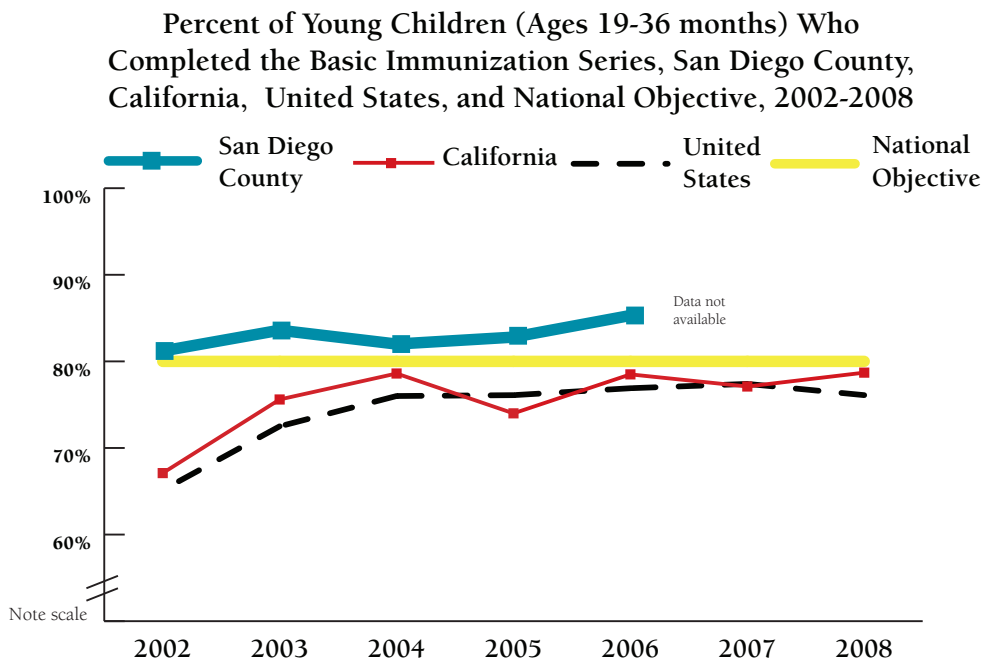
The percent of young children (ages 19-36 months) who completed the basic immunization series (4:3:1:3:3:1).

The childhood immunization indicator is the percent of young children (ages 19-36 months) who have received the current basic recommended childhood immunization series. While the basic series of vaccines are due by age 24 months, no data exist to track for children precisely that age. These data are collected from the Immunization Survey conducted every third year by the County of San Diego Health and Human Services Agency Immunization Branch.

Why is this important?

Childhood immunizations are highly effective and cost-effective. Vaccines prevent disease and keep children alive and healthy. A recent analysis of vaccines protecting against 10 diseases routinely administered to children estimated that \$9.9 billion in direct costs and \$43.3 billion in total costs are saved for each birth cohort of children vaccinated. This success is the result of a massive public/private partnership involving researchers, vaccine manufacturers, policy makers, public and private health professionals who administer vaccines, and, of course, families who voluntarily participate in immunization programs.

How are we doing?



The trend is gradually improving in San Diego County. We remain above state and national levels and have exceeded the national objective of 80 percent for the current recommended series.

What strategies can make a difference?

Since a national measles epidemic in 1990-91 alerted the nation to pockets of under-immunization among our youngest children, communities across the country — including San Diego County — have given attention to this issue. Assuring appropriate immunization requires awareness, financing, access, and vaccine distribution systems that work effectively and efficiently.

The following strategies have been used across the country to increase immunization:

- Assuring an adequate supply of affordable vaccine. For the basic early childhood series, this has largely been accomplished through the federal Vaccines for Children (VFC) program.
- Implementing immunization registries, which monitor who is up-to-date or has missed.
- Reaching out and providing support and information for families whose children are not up-to-date for recommended vaccines.
- Prioritizing groups at special risk, including families who refuse immunizations and those with less access.
- Using community-wide campaigns and education to inform parents about the importance of immunizing “every child by two” and the continued risk of vaccine-preventable disease.
- Providing access to vaccines through pediatricians, family physicians, local health departments, community clinics, and other locations.
- Educating health providers and parents about the importance and acceptability of giving vaccines, even if a child is mildly ill or at an office visit that is not a well child visit.
- Supporting providers with quality improvement projects such as AFIX (assessment, feedback, incentives and exchange), a nationally recommended quality improvement strategy to raise coverage levels and improve standards of practice at the provider level.
- Protecting providers who deliver vaccines from excessive liability costs and concerns by continuing the National Vaccine Injury Compensation Program.

How can we improve the trend in San Diego County?

We have made progress in the past decade. The San Diego County Immunization Coalition includes approximately 150 partner organizations working with the HHSA to identify and develop strategies to raise immunization coverage. The county also has a longstanding immunization registry that can help identify when children are not up-to-date on their vaccinations.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego Immunization Coalition, American Academy of Pediatrics, HHSA-Public Health, First 5 San Diego, parents and parent organizations, health providers, community-based organizations, faith communities, and 211 to:

1. Educate health providers and parents about giving vaccines, even at times when a child is mildly ill or at an office visit that is not a well child visit.
2. Partner with First 5 San Diego and HHSA to expand the community-wide campaign to inform parents and caregivers about the importance of immunization, particularly those who refuse immunizations and those with less access.
3. Offer management consultation to providers of childhood vaccines regarding quality improvement strategies such as AFIX.



“In the earliest years...we can prevent damage and promote the development of healthy brain architecture by providing rich learning opportunities in the context of stable and supportive relationships.” Jack P. Shonkoff, Director, Center on the Developing Child at Harvard University

Ages 3–6 (Preschool):

EARLY CARE AND EDUCATION

What is the indicator?

The percent of children ages 3-4 enrolled in early care and education.

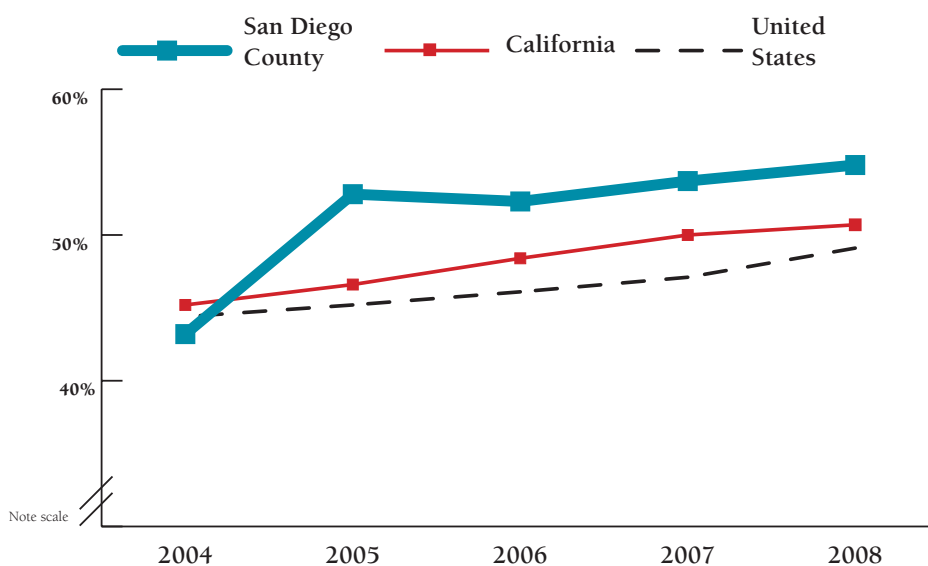
This indicator — the percent of children ages 3-4 enrolled in early care and education — shows trends in early childhood care and education for our county’s preschool age children who are regularly attending an out-of-home and non-relative early care and education setting. This setting may be a child care center, family child care setting (licensed or unlicensed), preschool, or Head Start program. The data is routinely gathered and reported by the U.S. Census Bureau American Communities Survey. Unfortunately, similar data are not routinely collected regarding children ages 0-3.

Why is this important?

Much is known about how young children grow, develop, and learn. Recent brain research and other studies demonstrate the importance of nurturing and enrichment, beginning with babies. Research shows that early childhood care and education in a quality setting (including child care, preschool, Head Start, etc.) can improve the school readiness and overall development of young children, as well as education and employment outcomes throughout life. Thus, quality early care and education from birth to five years can not only help a child, but also produce economic benefits to society that far exceed the initial investment. The greatest cost-benefit is through investments in low-income children.

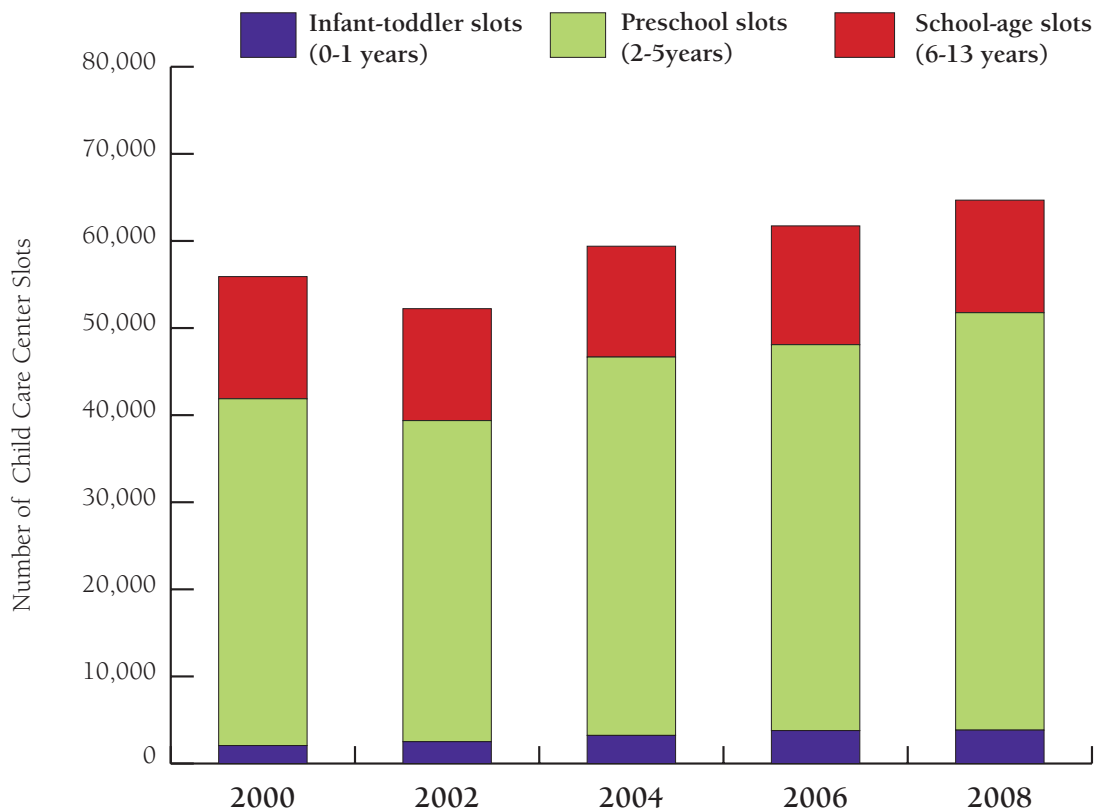
How are we doing?

Percent of Children Ages 3-4 Enrolled in Early Care and Education,
San Diego County, California, and United States, 2004-2008



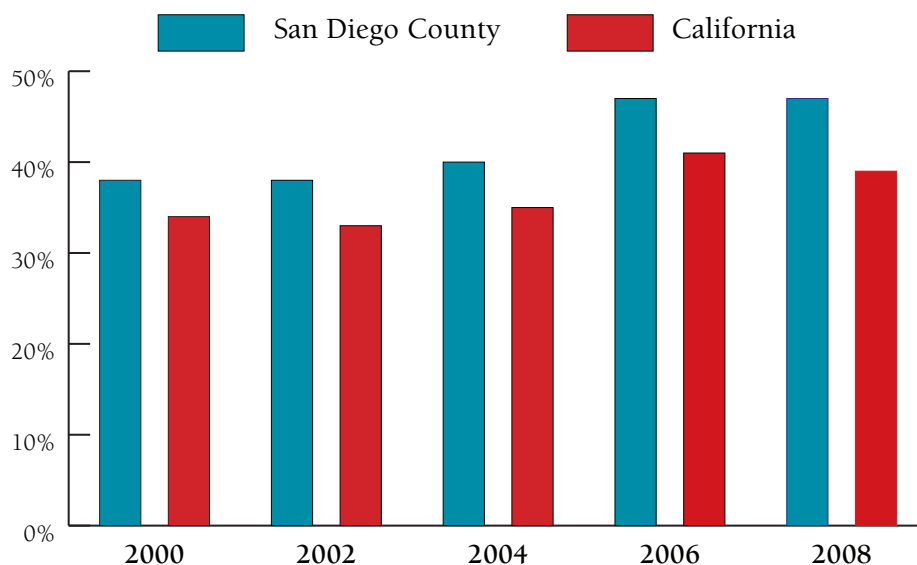
The trend is consistently improving. In 2008, 55% of 3 and 4 year olds were enrolled in early care and education, an increase from 43% in 2004. The percent of 3 and 4 year olds in San Diego County who are enrolled in early care and education rate is above the state and national averages.

**Percent of Licensed Child Care Center Slots, By Age of Child,
San Diego County, 2000, 2002, 2004, 2006, and 2008**



The majority of slots in licensed child care centers are for children ages 2-5. Only a small proportion are available for infants and toddlers from birth to the second birthday.

Percent of Parent Requests to Child Care Resource and Referral Agencies that were for Infant and Toddler Care, San Diego County and California, 2000, 2002, 2004, 2006, and 2008



The percentage of requests for infant-toddler care made to child care resource and referral agencies is increasing. This is in contrast to the low percentage of slots in licensed child care centers available for infants and toddlers.

What strategies can make a difference?

Early care and education includes child care, preschool/pre-kindergarten, and Head Start. While parents are a child's first teacher, most children spend a large proportion of their early years in the care of others. Over the past three decades, the economic and developmental impacts of early care and education have been extensively studied. Research shows that children in high quality early care and learning environments gain more advanced language, school readiness, and better social skills. Research also shows that teachers with bachelor's degrees and training in child development provide young children with better preparation to succeed in school and beyond. Efforts are aimed at assuring every child has an early care and education experience that fits their family's needs.

The following strategies have been used to increase the quality of early care and education:

- Implementing quality rating systems to give families information they need to identify quality programs.
- Providing child care subsidies for low-income families to assure access to quality early care and education.
- Adopting teacher training and credentialing standards associated with quality.
- Offering child care resource and referral lines or centers that assist families in finding services that meet their needs.
- Increasing access to and quality of infant and toddler care.
- Increasing access to quality preschool or pre-kindergarten (pre-K) programs and Head Start, which have been shown to provide a boost in skills for children ages 3 to 5.
- Providing technical assistance to family day care centers to insure good quality care and financial sustainability. Training and deploying child care health and mental health consultants to provide supportive services to children in early care and education settings.

How can we improve the trend in San Diego County?

San Diego has an array of early care and education initiatives. First 5 San Diego's Preschool for All program in partnership with the County Office of Education provides free, quality preschool to families in eight communities. The CARES (Comprehensive Approaches to Raising Educational Standards) program provides funding to providers who want to attend college to further their education, yet funding will be ending in 2010. The Child Care and Development Planning Council provides planning and program support countywide.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with First 5 San Diego, Child Care and Development Planning Council, child care resource and referral agencies, early care and education providers, community colleges and universities, faith communities, HHSA-Behavioral Health Services, mental health service providers, businesses, and municipalities to:

1. Increase the amount of available child care subsidies so that more low-income and working poor families have access to quality child care, particularly for infants and toddlers.
2. Train and fund more health and mental health consultants to provide services to improve the quality of early care and education settings.
3. Improve the quality of child care by providing more training opportunities and support for child care providers, as well as facilities improvements and educational materials.



“While the eyes may be the window to the soul, your mouth is a window to your body’s health.” Mayo Clinic

Ages 6–12 (School Age): ORAL HEALTH

What is the indicator?

The percent of children ages 2–11 who have never visited a dentist.

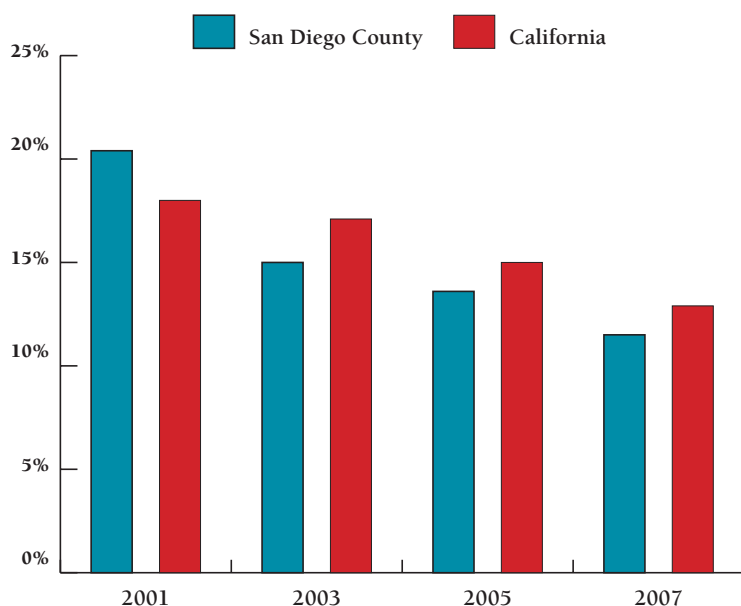
The indicator for oral health is the percent of children ages 2–11 who have never visited a dentist. This age range represents the most important years to prevent and treat dental disease and decay. Current national recommendations from dentists and pediatricians call for dental care to start at 12 months, and federal regulations call for children in Medi-Cal to be referred for dental care starting at age 24 months. These data are routinely reported in the California Health Interview Survey.

Why is this important?

Dental caries (the disease that causes cavities) is the single most common chronic disease of childhood. One-quarter of U.S. children — most poor, minority, and/or with special health needs — experience 80 percent of all decayed teeth. Even decayed “baby” teeth affect child health and adult teeth. Children with untreated cavities often live with pain, which affects concentration, school achievement, mood, sleep, nutrition, and play. By age 17, more than 7 percent of U.S. children have lost a permanent tooth to decay. Routine and preventive dental care is essential to: 1) educate families, 2) apply protection such as fluoride treatments and sealants, and 3) intervene for dental caries.

How are we doing?

**Percent of Children Ages 2–11 Who Had Never Visited a Dentist,
San Diego County and California, 2001, 2003, 2005, and 2007**



The trend has continued to improve over the last few years and the percent of San Diego County children ages 2–11 who have never seen a dentist is below the state average. Still, more than one in eight of our preschool and school age children have never had a dental visit.

What strategies can make a difference?

Dental care is an integral part of a complete health care system and important for assuring good oral health. Experts tell us that the key elements for assuring optimal oral health in children are: 1) sound nutrition, 2) effective “self-care” practices (e.g., brushing and flossing), and 3) access to dental prevention and treatment services through a “dental home” beginning at age one.

The following strategies have been used across the country to achieve success in improving the oral health status of children:

- Increasing children’s coverage for dental services, particularly through Medicaid/Medi-Cal and Healthy Families/Children’s Health Insurance Program (CHIP).
- Increasing the supply of trained dental professionals, including dentists and dental hygienists. (This strategy includes increasing the number of training slots in higher education and offering loan repayment options in exchange for serving in low-income communities.)
- Expanding access to dental services in low-income and underserved communities (e.g., dental services in community clinics, mobile dental clinics).
- Increasing effective use of primary health care providers (e.g., pediatricians), early childhood education (e.g., child care and Head Start), and other community organizations to educate parents about the importance of oral health and how to screen children for oral health problems.
- Assuring community water fluoridation.
- Helping families gain access to preventive services, including sealant and fluoride varnish applications.
- Implementing health promotion campaigns that increase families’ awareness of the importance of brushing and flossing (from infancy), as well as preventive dental visits.

How can we improve the trend in San Diego County?

The San Diego County Oral Health Report was updated in 2009. Through the Oral Health Initiative, oral health services and education are provided in five community clinics and four other programs. This comprehensive, countywide program includes screenings and examinations, sealant and fluoride varnishes, routine treatment, and high level care (root canals, etc.) for young children, and screening, exams, and treatment for pregnant women. The San Diego Dental Health Initiative/Share the Care facilitates emergency and preventive care to eligible children.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Oral Health Initiative, Dental Health Initiative, First 5 San Diego, HHSA-Public Health, dental and pediatric professional organizations, parents and parent organizations, community clinics, faith communities, school, and local media partners to:

1. Maintain and expand water fluoridation efforts.
2. Provide training to primary health care providers (e.g., pediatricians, nurse practitioners) and early childhood education providers (e.g., child care and Head Start) on how to educate parents about the importance of oral health and how to screen children for oral health problems.
3. Encourage each dental provider to accept as new patients five children with Medi-Cal coverage and become their dental home.



“Truancy and excessive absenteeism cause costly, long-term problems for students, schools, and the community.” California Department of Education

Ages 6–12 (School Age): **SCHOOL ATTENDANCE**

What is the indicator?

The percent of elementary school (K-5) students who did not attend school at least 95 percent of school days.

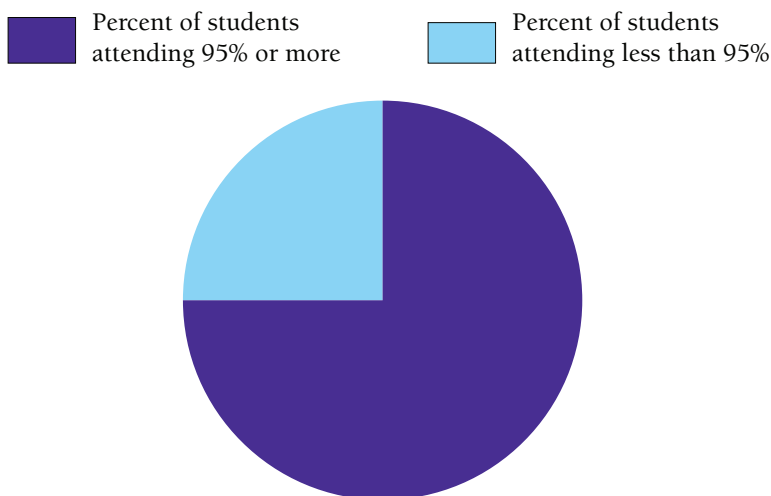
This indicator — the percent of elementary school (K-5) students who did not attend school at least 95 percent of school days — monitors school attendance based on 95 percent attendance on the Second Principal Apportionment (P2) reporting date of each district’s school year. It includes students who are absent approximately nine days of the school year, for any reason. These data include school districts representing 97 percent of the student population. Note, this is not average daily attendance.

Why is this important?

School attendance is one of the strongest predictors of school success or failure. Students in elementary school are learning the basic reading, writing, math, reasoning, social, and study skills that are critical to success and fulfillment in the higher grades. Without this foundation in place, the chances of graduating high school diminish. Whether children miss school as a result of illness, family vacations, or truancy, missing many days of school affects learning for all: the student who must catch up on missed learning; the teacher who must re-teach the material; the other students whose educational progress is slowed as a result.

How are we doing?

Percent of Elementary School Students (Grades K-5) Who Did Not Attend at Least 95% of School Days, School Year 2008-09



In San Diego County, 25% of students in grades K-5 attended less than 95% of school days in school year 2008-09. The threshold of 95 percent is more stringent for the elementary grades as basic skills are being learned.

What strategies can make a difference?

There are many factors that may affect a child's attendance at school, such as illness, transportation problems, child care, and parent illness. National studies state that to address frequent absences and truancies, schools, parents, community prevention and intervention providers, and law enforcement must work together to develop policies, services, and programs that support families.

The following strategies have been used across the country to improve attendance:

- Developing and implementing sound, reasonable, and well-communicated attendance policies.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., using multiple languages, the Internet, e-mail, and other forms of communication).
- Increasing parent and community awareness of the importance of regular attendance through education, outreach, and publicity.
- Providing positive reinforcement practices such as parent/student commendation letters and attendance rewards.
- Providing incentives for small improvements (e.g., weekly or monthly recognition).
- Providing early interventions that address the specific cause of absenteeism, particularly with elementary school students and their families. Such efforts include family involvement programs.
- Targeting interventions for students with chronic attendance problems.
- Linking schools, parents, health, and mental health professionals in efforts to reduce absenteeism.
- Creating a school climate and practices that promote parent and family involvement.

How can we improve the trend in San Diego County?

The Children's Initiative is working with elementary schools in eight different districts to implement effective practices to improve attendance. This "Data to Action" project conducted interviews with school personnel and parent focus groups to identify local barriers to attendance, needed resources, and possible interventions. These data were combined with guidance from local experts, schools with successful attendance programs, and national best practices to create a "toolkit" of attendance improvement practices and policies specifically designed for each school's needs. Schools will start implementing selected policies and practices in school year 2009-2010.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, families, parents and parent associations, community-based organizations, and local media partners to:

1. Implement specific and consistent school attendance improvement strategies.
2. Monitor attendance at individual school and district levels through monthly performance reviews.
3. Increase community awareness and family engagement through approaches such as *GAME On! (Good Attendance Means Everything)* or *Attendance Matters*.



“America’s future walks through the doors of our schools each day.” U.S. Department of Education

Ages 6–12 (School Age): **SCHOOL ACHIEVEMENT** **GRADE 3**

What is the indicator?

The percent of students in grade 3 scoring proficient or advanced on the English Language Arts achievement test.

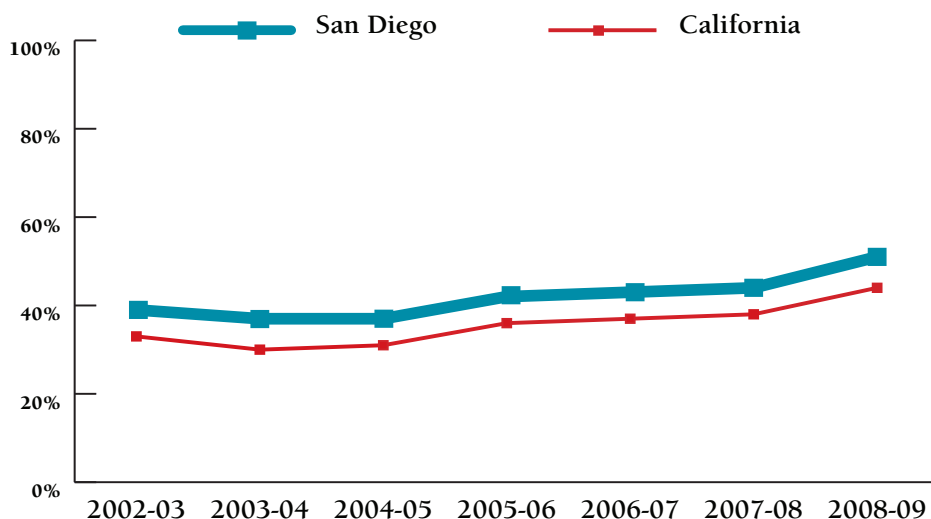
This indicator — the percent of students in grade 3 scoring proficient or advanced on the English Language Arts achievement test — measures students’ scores on the English Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. Administered annually to students in grades 2 through 11, STAR covers multiple subjects including English, Mathematics, Science, and History. These data are routinely reported by the California Department of Education.

Why is this important?

Performance on the English Language Arts test is widely accepted as the best predictor of school achievement overall, in part because mastery of English language skills is a critical foundation to understanding information taught about other subjects. Early attainment of basic English language skills is critical. In the primary grades, children are learning to read; but from that point on, they must read to learn. Moreover, poor readers are missing content learning that hinders them from learning other subjects. A child who does not master the basic learning skills does not have the foundation for future success.

How are we doing?

Percent of Students in Grade 3 Scoring Proficient or Advanced in English Language Arts Test, San Diego County and California, School Years 2002-03 to 2008-09



Between 2003 and 2008, the trend has improved substantially (from 39 percent to 51 percent). Our county remains well above the state average. Notably, the percent of Hispanic and African American children scoring proficient or advanced increased between 2007-08 and 2008-09 school years.

How can we improve the trend in San Diego County?

The best approach to instilling English Language Arts skills and other reading skills is to begin experience early and to incorporate reading skills into all areas of a child's life. What children see and practice at home, what is included in their play and entertainment, and how skills are fostered at school; all of these factors affect learning skills and school achievement.

The following strategies have been used across the country to increase proficiency in English Language Arts:

- Providing parent literacy support and education, particularly on school campuses.
- Offering intensive English Language Arts instruction including: phonics based instruction, word/language study, small group instruction, and use of interesting and relevant reading materials. This is particularly important before grade 3.
- Developing appropriate intervention programs, including before and after school, summer, and in-school reading support.
- Promoting independent reading and writing — at home and at school.
- Supporting reading across the curriculum in schools.
- Limiting time with television and video games.
- Providing mentors and tutors immediately for children who have started to fall behind in English Language Arts and learning.
- Targeting services for parents of young children who do not speak English or who speak English as a second language.
- Using teaching strategies and tools that are culturally and linguistically appropriate and relevant, including opportunities for students to share the richness of their cultural heritage and life experiences.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, First 5 San Diego, parents and parent associations, literacy and reading support organizations, libraries, and San Diego Council on Literacy to:

1. Implement a single, standardized, countywide kindergarten entrance assessment of school readiness and plan for immediate intervention when children lack basic pre-reading skills .
2. Expand the use of special reading programs that support early childhood and family literacy, such as *Raising a Reader* or *Reach Out and Read*.
3. Provide early reading intervention instruction through programs such as *Reading Recovery*, *UROC*, *Lindamood-Bell*, and other one-to-one or small group intensive interventions.



“Obesity and with it diabetes are the only major health problems that are getting worse in this country, and they’re getting worse rapidly.” Dr. Thomas Frieden, Director, Centers for Disease Control and Prevention

Ages 6–12 (School Age): **OBESITY**

What is the indicator?

The percent of students not in the Healthy Fitness Zone in grades 5 and 7.

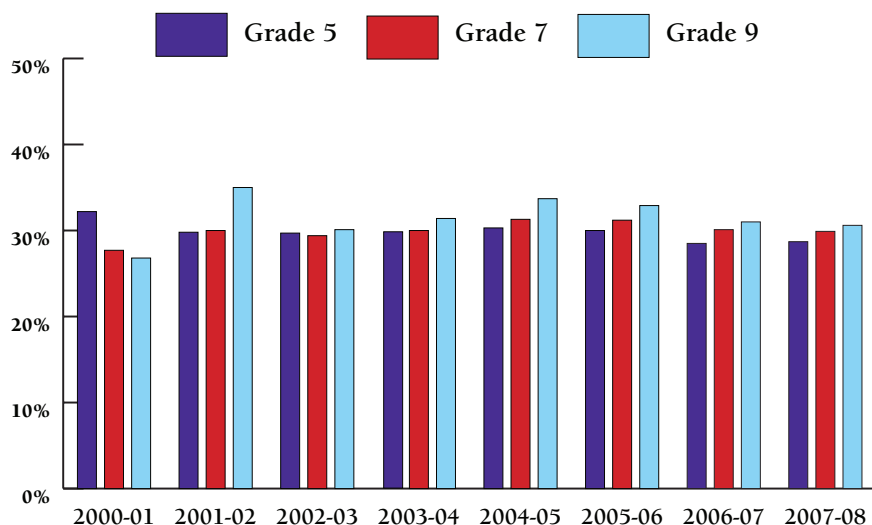
This indicator — the percent of students not in the Healthy Fitness Zone in grades 5 and 7 — measures overweight and/or obesity. The California Fitness Exam is a test of physical fitness given to students in grades 5, 7, and 9 every year, and it assesses the “Healthy Fitness Zone.” This indicator uses components of the test that measure body composition and body mass index (BMI). Students who score outside the upper end of a specified range are not in the Healthy Fitness Zone. These data are routinely reported by the California Department of Education.

Why is this important?

Being over healthy weight can have short and long term consequences for children’s health and well-being. A recent study found that 80 percent of children who were overweight at ages 10-15 were obese by age 25 years, as well as at increased risk for high blood pressure, high cholesterol, and type 2 diabetes. In addition to the physical health risks, many overweight and obese children experience social discrimination and bullying. Obesity is one of the top 10 leading health indicators for the Healthy People 2010 National Health Objectives.

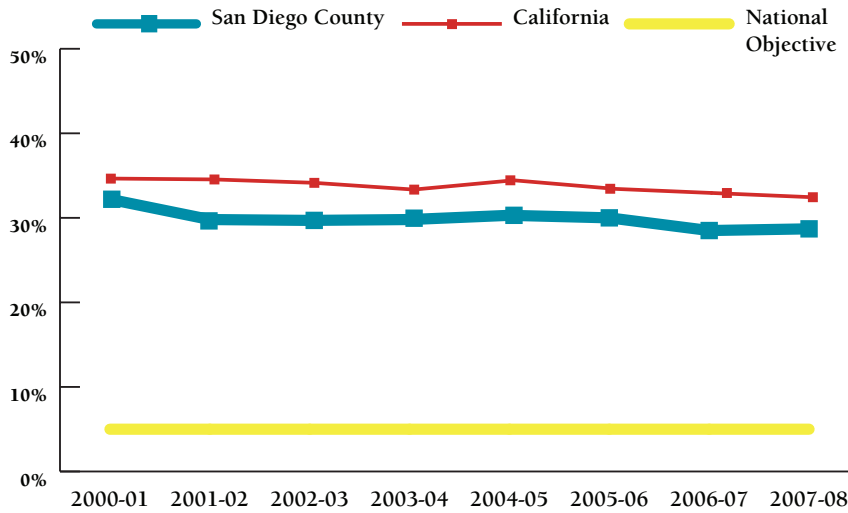
How are we doing?

**Percent of Students Not in Healthy Fitness Zone,
Grades 5, 7, and 9, San Diego County,
School Years 2000-01 to 2007-08**



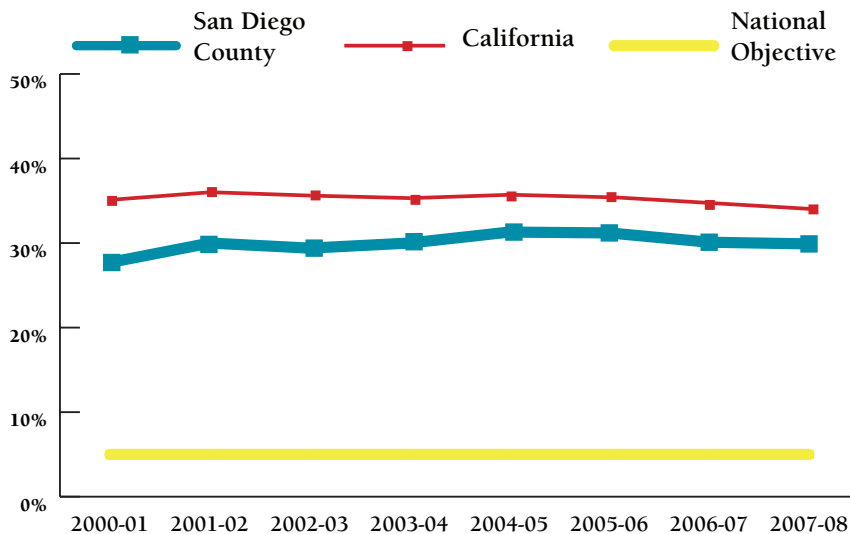
The trend is not improving. Although slightly below the state rates (not shown) for 5th, 7th, and 9th graders, San Diego is far from achieving the national objective of having no more than 5 percent of children and youth be overweight or obese.

Percent of Students Not in Healthy Fitness Zone, Grade 5, San Diego County and California, School Years 2000-01 to 2007-08



The trend is not improving. Approximately 30% of our 5th graders are not in the Healthy Fitness Zone and have a BMI that places them at risk. Although only slightly below the state average for grade 5, San Diego is far from achieving the national objective of 5%.

Percent of Students Not in Healthy Fitness Zone, Grade 7, San Diego County and California, School Years 2000-01 to 2007-08



Again, the trend is not improving. Approximately 30% of our 7th graders are not in the Healthy Fitness Zone and have a BMI above levels for optimal health.

What strategies can make a difference?

Communities across the country are taking action to reduce weight issues among children. Prevention, shown to be more effective than intervention, should be a primary focus. Communities should consider and aim to increase access to nutritious food, improve the physical environment, and modify social norms and expectations.

The following strategies have been used across the country to address weight and obesity issues:

- Increasing rates of breastfeeding.
- Developing fitness and weight assessments starting at kindergarten.
- Increasing healthy nutrition education and services to children and their parents.
- Encouraging smaller portion size options in schools and other public settings.
- Increasing routine physical activity for children in and out of school.
- Providing extended hours and nighttime lights and security at public parks, sporting complexes, school fields, and community recreation centers.
- Reducing access in schools and other public places to soft drinks, candy, and other foods high in calories, while low in nutrition.
- Expanding the availability and affordability of fresh fruits and vegetables in schools at all grades and in low-income neighborhoods.
- Requiring that public vending machines and snack bars have nutritious selections (water, fruit, low-fat and low-calorie snacks).
- Providing nutrition and physical fitness education in health care and education settings.
- Encouraging eligible families to participate in WIC. In 2009, the federal government released new guidance, and WIC now provides healthier foods, including fresh fruits and vegetables.

How can we improve the trend in San Diego County?

In 2002 the Health and Human Services Agency established the Coalition on Children and Weight, and in 2004 the Board of Supervisors declared childhood obesity a priority issue and called for the development of a countywide master plan to end childhood obesity. *A Call to Action: San Diego County Childhood Obesity Action Plan* was released in 2006, with an Obesity Initiative created to assure its implementation. The County Department of Parks and Recreation adopted nutritional guidelines for food and beverages sold at concession and vending machines. San Diego Regional Immunization Registry and the San Diego County Childhood Obesity Initiative have broken new ground by incorporating height and weight measurements into the San Diego Immunization Registry. All school districts that participate in the free/reduced lunch program are now required by federal law to have a wellness policy and many include policies to combat obesity.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego County Childhood Obesity Initiative, Health and Human Services Agency, San Diego County Office of Education, First 5 San Diego, parents and parent organizations, schools and school districts, 211, municipalities, community-based organizations, neighborhood associations, and faith communities to:

1. Assist schools in implementing federally mandated wellness policies and other fitness programs.
2. Encourage eligible families to participate in WIC to improve child nutrition starting at birth.
3. Promote physical activity and healthy eating habits through schools, community clinics, WIC centers, early care and education settings, and community centers.



“Chronic absenteeism, especially truancy, is a behavior that is highly associated with dropping out of school.” California Department of Education

Ages 13–18 (Adolescence): SCHOOL ATTENDANCE

What is the indicator?

The percent of middle and high school students (grades 6-12) who did not attend school at least 90 percent of school days.

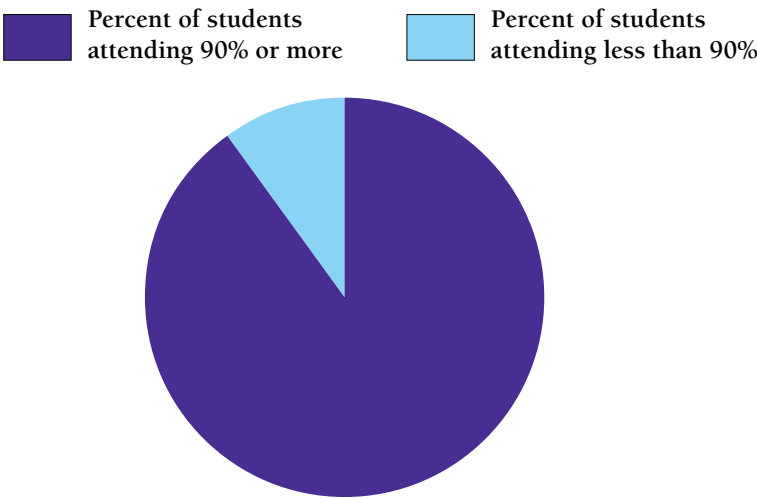
This indicator — the percent of middle and high school students who did not attend school at least 90 percent of school days — monitors school attendance based on 90 percent attendance on the Second Principal Apportionment (P2) reporting date of each district’s school year. It includes students who are absent approximately 18 days of the school year, for any reason. These data include school districts representing 97 percent of the student population. Note, this is not average daily attendance.

Why is this important?

School attendance is a very strong predictor of school success. Students who attend school 90 percent of the time have a much better chance of academic success, and academic success is strongly correlated with better employment and higher earnings. Students who attend regularly have stronger social relationships and connectedness to school. Chronically poor attendance is associated with lower achievement, lower test scores, literacy problems, dropout, and delinquent behavior. Poor attendance is not just truancy-related. Whether children miss school as a result of illness, family vacations, substance abuse problems, missing many days of school directly affects learning.

How are we doing?

Percent of Middle and High School Students (Grades 6-12) Who Did Not Attend at Least 90% of School Days, School Year 2008-09



In San Diego County, 10 percent of students in grades 6-12 attended less than 90 percent of school days in school year 2008-09.

What strategies can make a difference?

Best practices have demonstrated that to address attendance issues with middle and high school students we must bring together schools, parents, community providers, and law enforcement to develop policies, services, programs, and support that focus on both prevention and intervention services.

The following strategies have been used across the country to increase school attendance:

- Developing and implementing sound, reasonable, and well-communicated attendance policies.
- Developing accurate and daily monitoring of attendance, with feedback to parents (e.g., multiple languages, using the Internet, e-mail, and other forms of communication).
- Designing targeted outreach and education campaigns highlighting the importance of regular attendance to communities and families with high-risk students.
- Providing early and ongoing positive reinforcement practices such as parent/student commendations and attendance rewards.
- Providing early interventions that address the specific cause of absenteeism. Such efforts include family and caregiver involvement, tutoring programs, engaging students in service learning, and mentoring.
- Providing after school programs and activities to engage teens in the critical hours. Youth who attend after-school programs and/or engage in other after-school activities (e.g., sports, jobs, art, music) are less likely to miss school.
- Targeting interventions for students with chronic attendance problems, such as truancy reduction programs, smaller learning communities, and attendance intervention centers.
- Building linkages between schools, mental health providers, and law enforcement.
- Keeping students safe and supported at school and on their way to and from school.

How can we improve the trend in San Diego County?

As part of the American Recovery and Reinvestment Act (ARRA, also known as the stimulus bill), the U.S. Department of Labor provided counties with funds for summer employment of eligible youth ages 14 to 24 in 2009. Managed by San Diego Workforce Partnership, this program was a huge success in San Diego County, with over 3,200 youth placed in summer jobs countywide. Plans are in place to implement a 2010 summer jobs campaign. San Diego Unified School District is examining the rates of attendance, grades and overall performance for the 600 of their students benefited by this program to measure improvement.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, San Diego Workforce Partnership, parents and parent associations, local businesses, law enforcement agencies, Probation Department, and community-based organizations to:

1. Develop and implement effective school policies and practices related to attendance (e.g., collect and review attendance data, identify students who are absent, and take action).
2. Increase parent involvement with schools and attendance issues.
3. Increase student connections to school through the use of service learning, school to work opportunities, and college, career, and technical education programs.



“The foundation of every state is the education of its youth.” Diogenes

Ages 13–18 (Adolescence): **SCHOOL ACHIEVEMENT GRADES 8 AND 11**

What is the indicator?

The percent of students in grades 8 and 11 scoring proficient or advanced on the English Language Arts achievement test.

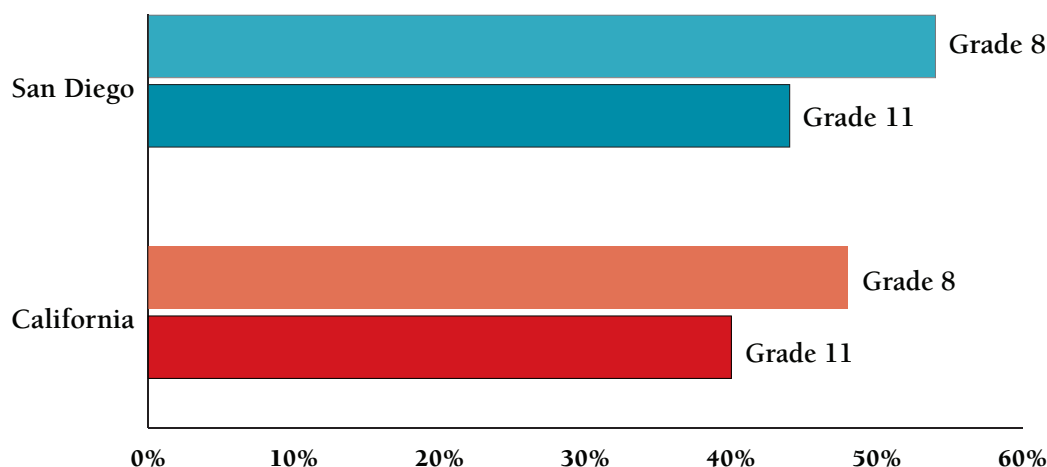
This indicator — the percent of students in grade 8 and 11 scoring proficient or advanced on the English Language Arts achievement test — measures students’ scores on the English Language Arts test of the annual California Standardized Testing and Reporting (STAR) program. Administered annually to students in grades 2 through 11, STAR covers multiple subjects including English, Mathematics, Science, and History. These data are routinely reported by the California Department of Education.

Why is this important?

Reading and English Language Arts skills are one of the best predictors of school success and achievement. Low literacy is one of the greatest predictors of not finishing school. School success is a critical predictor of good outcomes in many vital areas of life. High school achievement is associated with positive self-image, resistance to delinquency, increased likelihood of graduation and college attendance, and higher earnings. Poor English Language Arts and reading skills are correlated with unemployment and poverty as an adult. Currently, the 25 fastest growing careers have the highest literacy demands, while those careers most quickly declining have lower literacy demands.

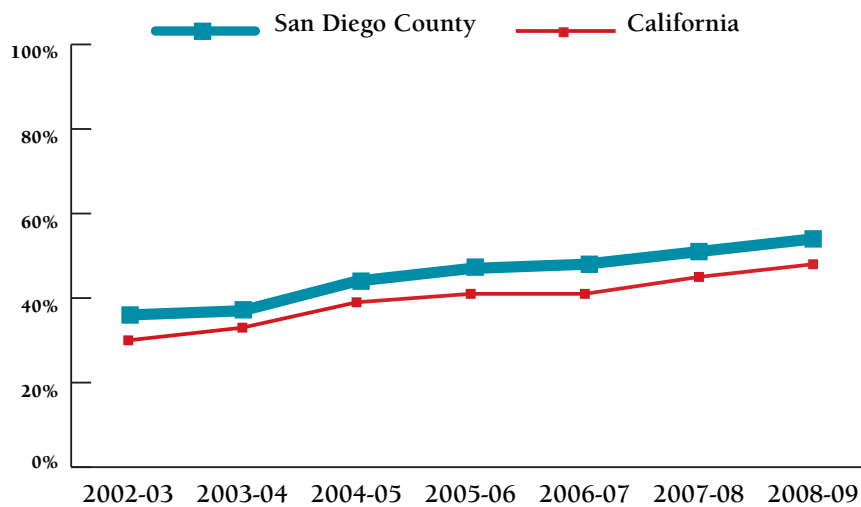
How are we doing?

**Percent of Students Scoring Proficient or Advanced in
English Language Arts Test, Grades 8 and 11,
San Diego County and California, School Year 2008-09**



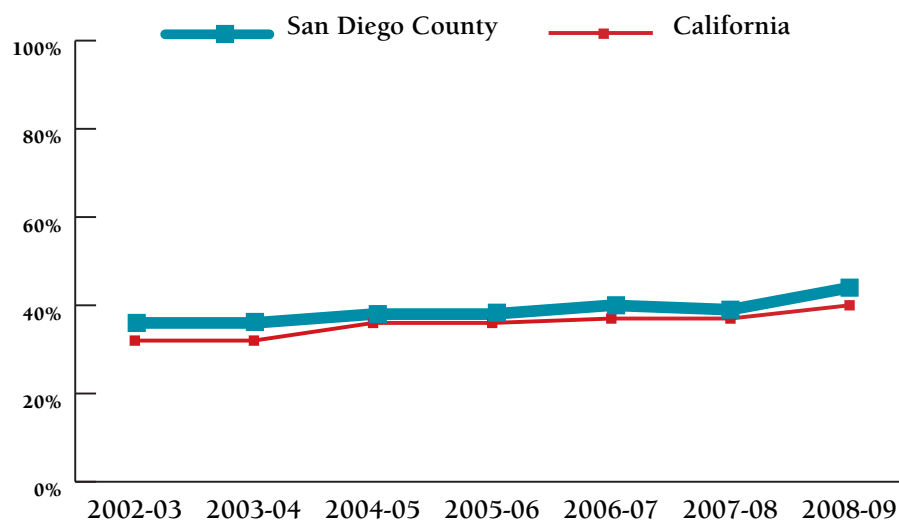
Younger students fare better than older students. While more than half of our 8th graders are scoring proficient or advanced in English Language Arts, the percentage drops to 44 percent by 11th grade. San Diego student scores are higher than the state averages.

Percent of Students Scoring Proficient or Advanced in English Language Arts Test, Grade 8, San Diego County and California, School Years 2002-03 to 2008-09



The trend for San Diego County is improving substantially, going from 36 percent to 54 percent for 8th graders between school years 2002-03 and 2008-09.

Percent of Students Scoring Proficient or Advanced in English Language Arts Test, Grade 11, San Diego County and California, School Years 2002-03 to 2008-09



The trend for San Diego County is improving, going from 36 percent to 44 percent for 11th graders between school years 2002-03 and 2008-09.

What strategies can make a difference?

Detection of learning and achievement problems and intensive intervention are critical at higher grades. As students enter middle and high school, feeling successful at school and connected to school becomes increasingly important for staying in school and graduating. Studies have shown that smaller learning communities can result in improved academic achievement, lower dropout rates, and narrowed achievement gaps for underprivileged students.

The following strategies have been used across the country to increase proficiency in English Language Arts:

- Improving students' feelings of connection to school.
- Encouraging reading and writing at school and at home (e.g., access to reading materials of interest, journal writing).
- Increasing focus on reading comprehension.
- Providing ongoing rewards and incentives for small improvements in reading skills.
- Providing specialized reading trainings and instructional strategies for teachers and classroom support staff.
- Developing appropriate intervention programs, including before and after school, summer, and in-school reading support.
- Expanding and targeting supportive services to underperforming students (e.g., reading specialists, mentors, tutors, one-to-one instruction).
- Evaluating and addressing underlying issues of poor academic performance (e.g., substance abuse, mental health, safety concerns).
- Developing smaller schools, schools within school models, and industry specific academies.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, California Department of Education, San Diego Workforce Partnership, local businesses and business associations, substance abuse prevention programs, mental health providers, and reading support organizations to:

1. Develop smaller schools, schools within schools, and career and technical academies.
2. Provide academic intervention such as trained reading specialists and core academic tutors during the school day, in after school programs, and in summer and intersession programs.
3. Provide social intervention services such as substance abuse and mental health counseling, summer work experiences, mentoring, and internships.



“Teen smoking can signal the fire of alcohol and drug abuse or mental illness, like depression and anxiety.” Joseph Califano, former U.S. Secretary of Health and Human Services

Ages 13–18 (Adolescence): **SUBSTANCE ABUSE**

What is the indicator?

The percent of students (grades 7, 9, and 11) who reported using cigarettes, alcohol, or marijuana in the past 30 days.

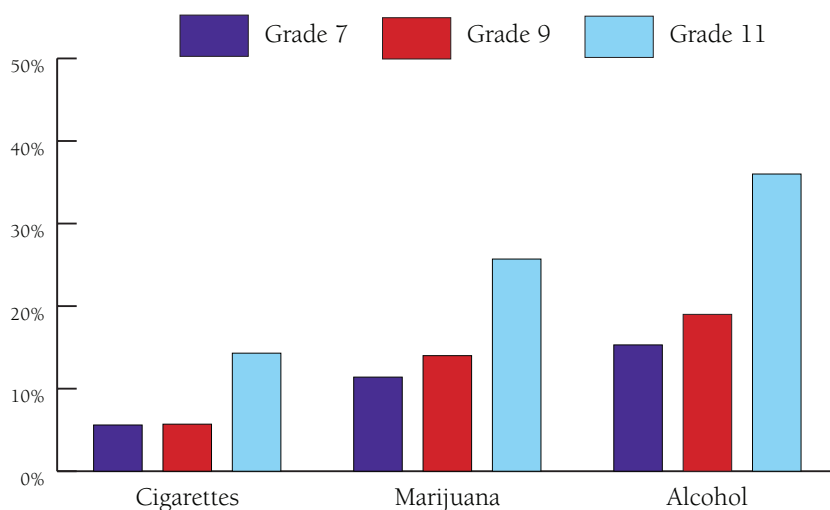
This indicator reports the percentage of students in grades 7, 9, and 11 who report having used cigarettes, alcohol, or marijuana in the last 30 days. These data are collected with the California Healthy Kids Survey, administered biennially to students in grades 7, 9, and 11 throughout the state of California. These questions mirror the questions in the Youth Risk Behavior Survey, a CDC-designed survey in use across the country.

Why is this important?

The use of cigarettes, marijuana, alcohol, and methamphetamines can stunt an adolescent’s physical and mental development. These drugs are a gateway to other drugs, increase the likelihood of engagement with the criminal justice system, and can escalate to lifelong additions. Studies show that prolonged use of alcohol and drugs can negatively impact academic success, relationships with others, job potential, and mental health. Misuse of prescription medications and smokeless tobacco are increasing. Medications commonly abused by youth include pain relievers, tranquilizers, stimulants, and depressants.

How are we doing?

Percent of Students Grades 7, 9, and 11 Who Reported Use of Cigarettes, Marijuana, or Alcohol in Past 30 Days, San Diego County, School Year 2008-09



The trends are not improving. The percent of students reporting use of cigarettes, marijuana, and alcohol increased from 2007 to 2009. Older students remain more likely to use substances.

What strategies can make a difference?

To address substance abuse issues, strategies must focus on both prevention and intervention policies, services, and programs. Services are most effective when they are available immediately after identification of issue, community based, and holistic.

The following strategies have been used across the country to decrease young people's use of cigarettes, alcohol, and drugs:

- Increasing students' ability to resist social pressure to abuse cigarettes, alcohol, and drugs through school-based programs such as life skills training.
- Teaching parents of preteens and younger adolescents the skills they need to improve family communication and bonding through programs such as *Guiding Good Choices*.
- Building resistance, resiliency, social competency, and problem-solving skills.
- Promoting youth development including increasing connectedness to school.
- Enforcing local ordinances prohibiting the sale of cigarettes and alcohol to minors.
- Working with parents and community to educate about the dangers of substance abuse.
- Working with parents, schools, and community to eliminate youth access to cigarettes, alcohol, and drugs.
- Incorporating culturally competent and relevant substance abuse education, especially in areas with a high density of minority youth.
- Increasing availability of community-based drug and alcohol treatment programs, both day treatment and residential.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, parents and parent associations, San Diego County Office of Education, HHSA-Alcohol and Drug Services, substance abuse prevention agencies, Probation Department, law enforcement, municipalities, community-based organizations, faith communities, and media partners to:

1. Promote youth development activities, after school programs and early prevention programs including: Community Assessment Teams, Friday Night Live, *Club Live*, *Botvin's Life Skills Training*, and ASES and ASSETS after school programs.
2. Expand access to treatment and evaluate regional needs for culturally competent services.
3. Conduct a "know the signs" campaign for parents.



“Suicide is a permanent solution to a temporary problem.” Yellow Ribbon Foundation

Ages 13–18 (Adolescence): YOUTH SUICIDE

What is the indicator?

The percent of students who reported they attempted suicide in the previous 12 months.

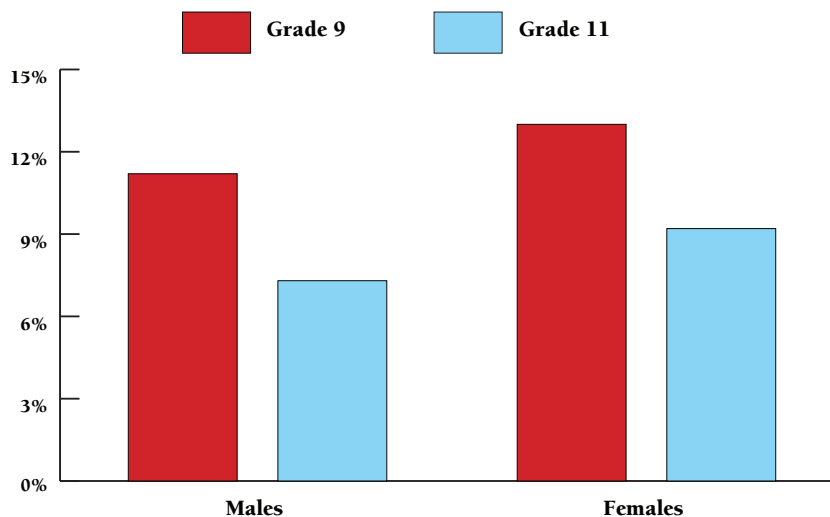
This indicator reports the percent of high school students who self-report having made a suicide attempt in the previous 12 months. These data are collected and reported on Module C, part of the California Healthy Kids Survey, which is administered in secondary schools on a biennial basis and reported by the California Department of Education and WestEd.

Why is this important?

Each year approximately 13 San Diego youth commit suicide. Other youth are hospitalized as a result of attempted suicide. The three most common methods among young people are firearms, suffocation, and poison. In addition to the tragedy of death, suicide has a lasting emotional and even traumatic effect on the community, particularly family and friends. Survivors are left with emotions of guilt, grief, and confusion that can be debilitating. Perhaps most important is the fact that suicide is often preventable.

How are we doing?

Percent of Students Grades 9 and 11 Who Reported They Had Attempted Suicide in the Past 12 Months, By Gender, San Diego County, School Year 2008-09



The trend is moving in the wrong direction. An increase in attempted suicide was reported for males and females in both 9th and 11th grades in school year 2008-09.

What strategies can make a difference?

Youth suicide prevention depends on community, family, and youth education. Youth typically do not contact professional help when they are depressed. Peers, teachers, health professionals, and parents are the people most likely to have contact with a depressed youth, and thus in the best position to intervene.

The following strategies have been used across the country to prevent youth suicide:

- Raising community and family awareness of the signs of depression and suicidal ideation (i.e., thinking about committing suicide).
- Emphasizing and reinforcing the fact that suicide is preventable.
- Educating peers and adult “gatekeepers” (e.g., teachers, school bus drivers, coaches) to recognize the warning signs and risk factors associated with suicide.
- Reducing the stigma associated with seeking support and help for depression and other mental health problems.
- Education for parents and others about reducing access to lethal means, particularly firearms which remain a major means used by youth who attempt suicide.
- Expanding school-based programs that promote help-seeking behavior, provide assessment, motivational counseling, problem-solving skills, and peer support, as well as reconnecting youth to their school and peer group.
- Training peers to respond to suicidal statements as an emergency, particularly to tell a trusted adult and use crisis hot lines.
- Providing interventions tailored to at-risk youth of various cultural and ethnic backgrounds.
- Improving data to better identify populations at risk.

How can we improve the trend in San Diego County?

San Diego Unified School District will begin implementing a major suicide prevention program in 2010. Funded by HHSA-Behavioral Health Services, this four-year project will train middle and high school students, as well as school personnel including nurses, counselors, psychologists, and teachers, to identify signs of suicidal ideation, intervene, and provide resources. The Light for Life Foundation/Yellow Ribbon Program has provided education, awareness, and support for the prevention of youth suicide in San Diego since 1997, including a variety of school-based training.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, American Academy of Pediatrics, HHSA-Behavioral Health Services, mental health providers, parents and parent organizations, faith communities, community-based organizations, and suicide prevention programs to:

1. Provide education—starting early before high school—for families, caregivers, health care providers, educators, school staff, mental health providers, and peers about the warning signs and risk factors of depression and suicide, as well as protective factors that reduce the likelihood of suicide.
2. Support additional mental health training and services and access to a variety of clinical interventions, as well as programs which focus on suicide prevention such as Yellow Ribbon Suicide Prevention Program, QPR-Question, Persuade and Refer, and Safe TALK.
3. Increase the number of school districts that administer suicide questions (Module C) of the California Healthy Kids Survey.



“Gang life and violence is like an illness in our community and unless we treat it immediately and aggressively, our kids are in serious jeopardy.” Jose Huizar, Los Angeles City Council

Ages 13–18 (Adolescence): JUVENILE CRIME

What is the indicator?

The number of arrests for misdemeanor and felony crimes among youth ages 10-17.

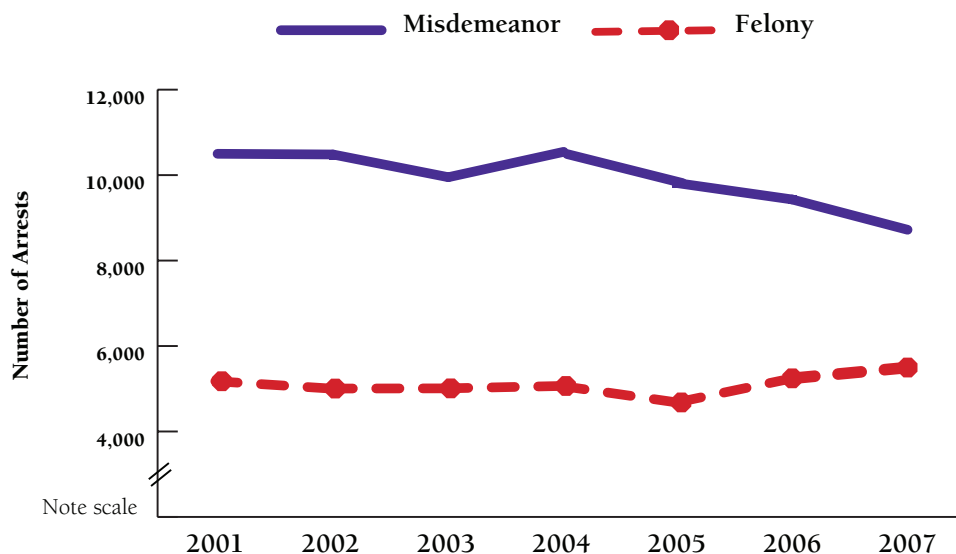
This indicator reports the number of arrests for misdemeanor and felony crimes among youth ages 10-17. Arrests for status offenses such as curfew violations or truancy are not included. One arrest may have more than one charge associated with it. Only the most serious offense is reported in each arrest. These data are collected by law enforcement, stored in Automated Regional Justice Information System (ARJIS), and routinely reported by SANDAG.

Why is this important?

Juvenile crime is costly on multiple levels. First and foremost, there is the potential loss of a productive life for the young person. In addition, crime costs victims their property, money, health, and sense of well-being, and it diminishes the sense of safety in the community. There are indirect costs for families and neighborhoods in terms of lost work time and property values. Other costs to government accrue in the juvenile justice system, health care system, and law enforcement.

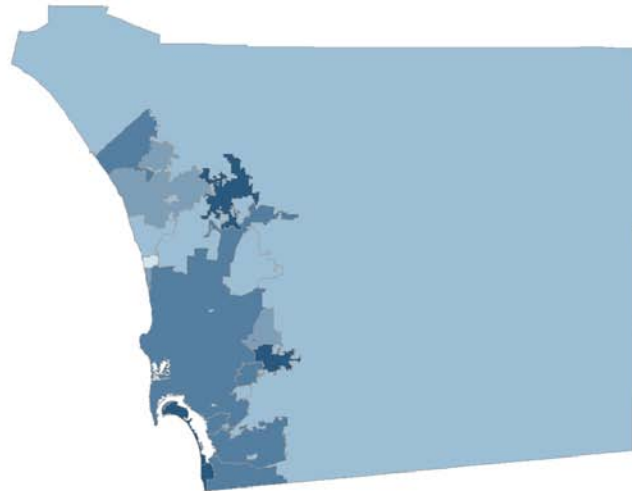
How are we doing?

Number of Arrests for Felony and Misdemeanor Offenses,
Youth Ages 10-17, San Diego County, 2001-2007

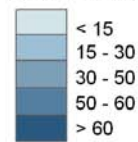


The number of juvenile arrests for felonies is increasing, while the number of misdemeanor arrests continues to decline.

RATE OF ARRESTS PER 1,000 YOUTH AGES 10-17: 2007



Rate of Juvenile Arrests



Overall County Rate	49.9
California Rate	50.1

NOTE: Data from California Department of Justice, Criminal Justice Statistics Center. Rates calculated using SANDAG 2007 demographic estimates.

The areas with the highest juvenile arrest rates include El Cajon, Escondido, and Imperial Beach.

Ten Most Common Crimes Committed By Juveniles, Ages 10-17, San Diego County, 2007

Crime		
	Level	Number
Petty theft	Misdemeanor	1,825
Aggravated assault	Felony	1,299
Drug violations	Misdemeanor	1,217
Burglary	Felony	1,183
Manslaughter/assault and battery	Misdemeanor	1,033
Drunk/liquor laws	Misdemeanor	973
Weapons offenses	Felony	609
Vandalism	Misdemeanor	559
Robbery	Felony	488
Larceny	Felony	427

The largest number of crimes committed by youth was in the category of petty thefts, followed by aggravated assault and drug violations.

What strategies can make a difference?

Studies show that identifying young people when they first begin to experiment with unhealthy and risky behaviors and providing them with programs that focus on prevention and early intervention service can keep them from entering the juvenile justice system.

The following strategies have been used across the country to decrease the incidence of juvenile crime:

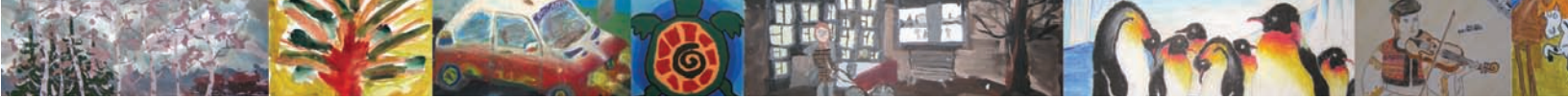
- Providing quality after school programs for elementary, middle, and high school students.
- Providing substance abuse prevention and intervention programs.
- Expanding access to mental health services for elementary, middle, and high school students.
- Offering literacy support.
- Expanding use of life skills training, vocational education, career development programs, internships, and employment opportunities.
- Developing problem-solving, anger management, mediation, and conflict resolution instruction.
- Expanding prevention programs to elementary and middle school youth that reduce gang involvement, connect youth to school, and encourage positive, pro-social behavior.
- Supporting community policing practices.
- Expanding Juvenile Diversion programs, and truancy identification and support.
- Using “Project Safe Neighborhoods” — a federal initiative to address gun crime and violence administered through the U.S. Attorneys’ Office.
- Developing and implementing juvenile accountability practices that include skill building, reparation to victims, and community service.

How can we improve the trend in San Diego County?

The San Diego Truancy Diversion Project—a partnership of the Children’s Initiative, local school districts and community-based organizations—provides mentoring, case management and academic support to students identified as truant and at risk for court involvement. The Children’s Initiative also works with San Diego Project Safe Neighborhoods to implement a mentoring program for incarcerated youth that have been involved with gun violence and gangs.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, local law enforcement agencies, community-based organizations, Juvenile Court, District Attorney’s Office, San Diego Workforce Partnership, parents and parent organizations, schools, faith communities, and local businesses and business associations to:

1. Expand internship programs, job shadowing, and summer and after school employment opportunities for middle and high school youth.
2. Expand early prevention and intervention programs such as Community Assessment Teams, Juvenile Diversion, Truancy Intervention program, after-school programs, mentoring, and mental health programs.
3. Provide assessment using the *Regional Resiliency Checkup* and intervention services such as Truancy Suppression or Community Service, at first school suspension or truancy arrest.



“We are willing to spend the least amount of money to keep a kid at home, more to put him in a foster home and the most to institutionalize him.” Marian Wright Edelman

Ages 13–18 (Adolescence): JUVENILE PROBATION

What is the indicator?

The number of sustained petitions (“true finds”) in Juvenile Court among youth ages 10-17.

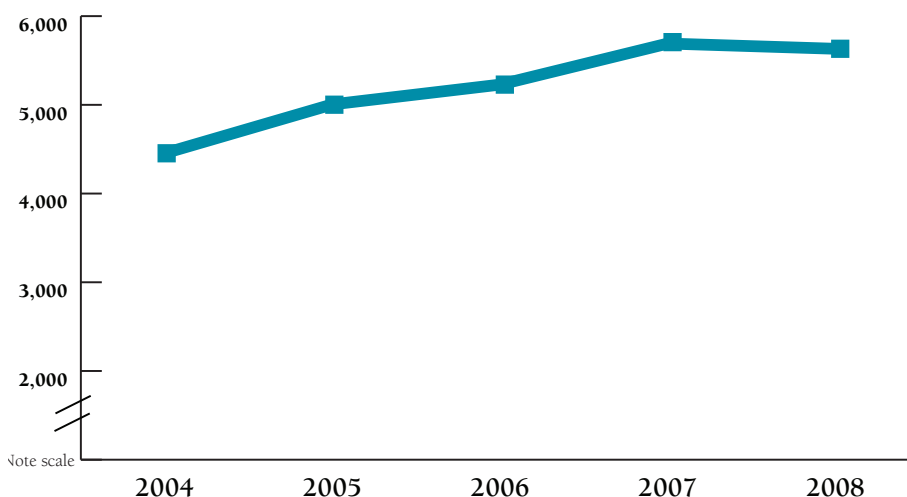
This indicator reports the number of sustained petitions (true finds) in the juvenile court system —the juvenile equivalent of being found guilty in adult court — among youth ages 10-17. This indicator includes only sustained petitions for misdemeanor or felony offenses. Status offenses such as curfew or truancy violations are not included here. These data are provided by the San Diego County Probation Department.

Why is this important?

Breaking the law and engaging in risky and dangerous behaviors negatively affect a young person’s life, education, and career options. When a youth enters the juvenile justice system and has a sustained petition, they are placed on probation. While probation is an important tool, it is costly for the public and often represents failure to address early warning signs of risky behavior and problems among youth. Probation generally comes following more serious or escalation of criminal behavior. Changes in the trend may reflect the number of youth committing felony crimes, number of cases being referred to court, direction of court decisions, and use of intervention and diversion programs.

How are we doing?

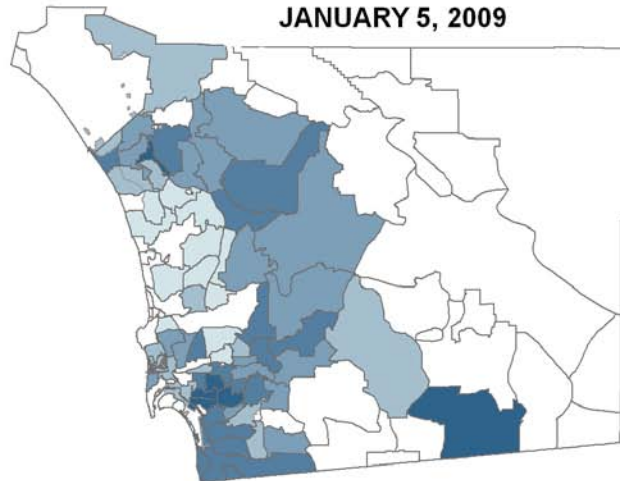
Number of Sustained Petitions (“True Finds”) in Juvenile Court, Youth Ages 10-17, San Diego County, 2004-2008



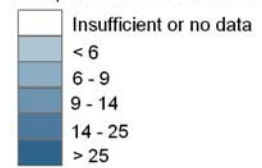
The number of sustained petitions has been increasing since 2004, with a slight drop in 2008.

RATE OF YOUTH AGES 10-17 ON PROBATION PER 1,000 YOUTH AGES 10-17:

JANUARY 5, 2009



Rate of Juvenile Probation
for zip codes with incidence >9



Overall County Rate 14.3

NOTE: 2009 Probation data were provided by the County of San Diego Probation Department. Rates calculated using SANDAG 2009 demographic estimates. Zip codes with juvenile probation incidence under 10 not included in rate calculations.

Juvenile probation rates are highest in Central San Diego; however, many areas approach the average rate for county youth at 14.3.

What strategies can make a difference?

Providing youth with support and clear, direct, and immediate consequences when they are engaging in risky behaviors and breaking the law provides youth with an understanding of appropriate boundaries, an opportunity to learn from their mistakes, and the ability to get back on track. Treatment, consistent and direct community supervision, and when needed, incarceration have been found to be effective in preventing increased delinquent behaviors, reducing recidivism, and improving public safety.

The following two categories of strategies have been used across the country to reduce arrests and escalation in the justice system:

Incarceration Phase:

- Mental health evaluation and clinical supervision, substance abuse services, and cognitive-behavior treatment.
- Educational and literacy services.
- Vocational education and career development support.

Treatment and Community Supervision Phase:

- Community-based drug treatment (day and/or residential services).
- Job training and employment assistance.
- Assertive Community Treatment, Multisystemic Therapy (MST), Functional Family Therapy, and/or Aggression Replacement Training.
- Wraparound support/coordination of services among support providers, law enforcement, and community partnerships.
- Interventions to reduce gang recruitment and to help gang-involved youth exit a gang lifestyle.
- Victim/Offender Mediation, empathy training, and restitution.
- Parent training to improve family communication, negotiation, and decision-making skills and to establish positive discipline.

How can we improve the trend in San Diego County?

San Diego County has many effective prevention and intervention programs, including Community Assessment Teams, Juvenile Diversion, and Breaking Cycles. Such programs typically have a more than 80 percent success rate in keeping kids out of or from escalating in the juvenile justice system. The federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) highlighted San Diego County as one of the three most successful Comprehensive Strategy pilots in the nation.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the Probation Department, Juvenile Court, local law enforcement agencies, Juvenile Diversion programs, community-based organizations, parent and parent organizations, school districts, faith communities, San Diego Workforce Partnership, HHSA-Alcohol and Drug Services, substance abuse prevention programs, and mental health service providers to:

1. Increase job training and employment assistance for higher risk youth and court-involved youth, as well as job shadowing and summer and after school employment opportunities.
2. Evaluate community needs and gaps in services and expand successful prevention programs to match community needs.
3. Expand Juvenile Diversion services with law enforcement and schools throughout San Diego County for high school and middle school students who are suspended, are expelled, commit lower level misdemeanors, or are habitually truant.



“Drunk driving is the nation’s most frequently committed violent crime.”

Glynn Birch, MADD National President

Ages 13–18 (Adolescence):

YOUTH DRIVING UNDER THE INFLUENCE (DUI)

What is the indicator?

The number of DUI arrests among youth under age 18.

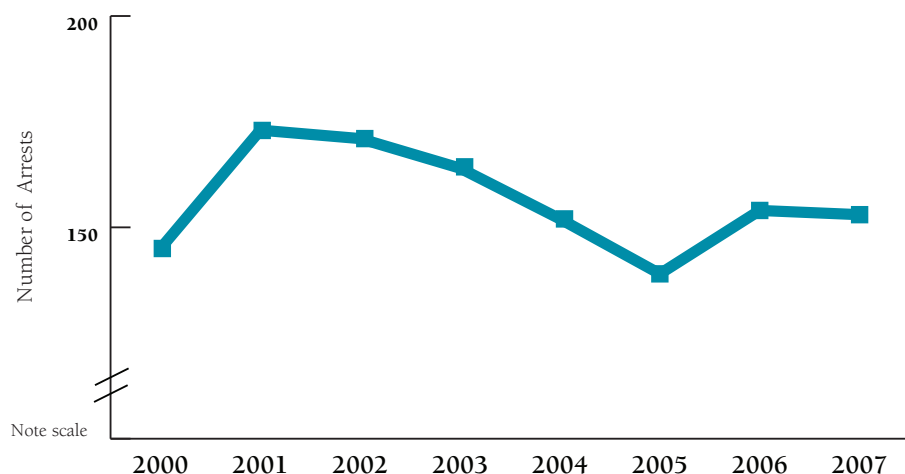
This indicator is the number of Driving Under the Influence (DUI) arrests among youth under age 18 as reported by the California Department of Motor Vehicles. It was selected as a gateway indicator for youth involved in alcohol- and drug-related collisions. Examining the statistics about our youth driving under the influence will help to identify opportunities for prevention and intervention, rather than looking only at the tragic end result of death and injury collisions.

Why is this important?

Driving under the influence is a serious hazard to health and safety. Less than 1 percent of drivers who self-report driving under the influence are caught and arrested for DUI. One-sixth of all children who die in motor vehicle crashes are riding with a drinking driver. Youth in the age group for this indicator are not of legal age to drink, and research shows that early onset of drinking is associated with more frequent heavy drinking and likelihood of subsequent injury while drinking.

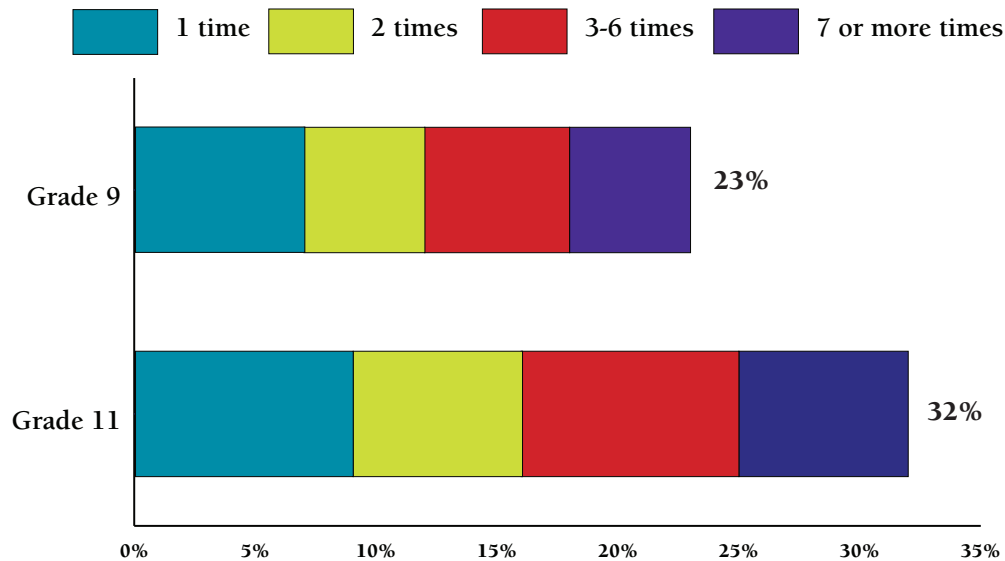
How are we doing?

**Number of DUI Arrests, Youth Under Age 18,
San Diego County, 2000-2007**



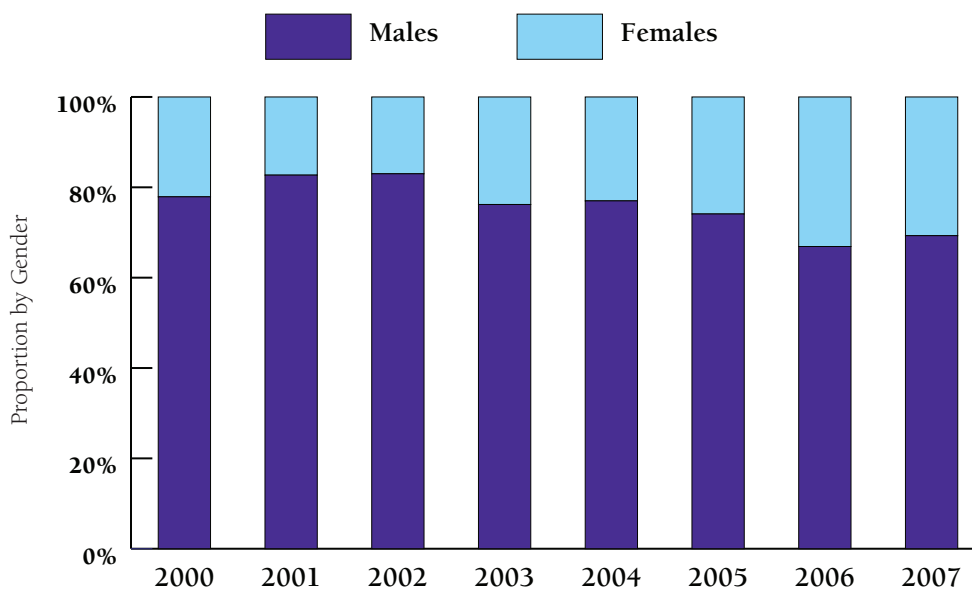
The trend is not improving overall in San Diego County. After declining from 2001 to 2005 the number of youth DUI arrests is increasing again.

Percent of High School Students Driving or Riding with Friends Who Had Been Drinking, San Diego County, 2007



In 2007, 23 percent of 9th graders and 32 percent of 11th graders reported that they had ever been in a car with a person who had been drinking. For some youth, this is a frequent occurrence, even within a month's time.

Proportion of DUI Arrests, Under Age 18, By Gender, San Diego County, 2000-2007



The proportion of DUI arrests that are to females is increasing.

What strategies can make a difference?

Driving under the influence is a behavior affected and supported by multiple factors, including social practices, perception that discovery and consequences are unlikely, impaired judgment and decision making, denial, convenience, and peer group pressures.

The following strategies have been used across the country to reduce DUI among young people:

- Aggressively enforcing existing blood alcohol level laws, minimum legal drinking age laws, and zero tolerance laws for drivers younger than 21 years old in all states.
- Promptly suspending the driver's licenses of people who drive while intoxicated.
- Conducting sobriety checkpoints targeted at communities with highest incidences of alcohol- and drug-related accidents.
- Expanding health promotion efforts that use an ecological framework to influence economic, organizational, policy, and school/community action.
- Prohibiting wireless telephone use (even hands free) and "texting" among youth while driving.
- Developing multi-faceted community-based approaches to alcohol control and DUI prevention, particularly focused on youth.
- Reducing youth access to alcohol.
- Changing social norms regarding the use of alcohol and drugs.
- Empowering youth and building resistance and problem-solving skills through youth development opportunities.
- Educating parents about the risks and liabilities of "supervised" drinking.

How can we improve the trend in San Diego County?

In recent years, San Diego and California have already implemented several best practices in preventing youth DUI, such as graduated driver licensing, increased DUI penalties, prohibitions on cell-phone calls and texting while driving, school-based education programs, and sobriety checkpoints on holidays. State Assemblyman Torlakson introduced AB 508, which would have restored driver education and training to public schools and provided grants to local educational agencies to offer the driver education and training program; however, the bill was defeated in 2009. Funding would have come from a \$10 fee to provisional license applications.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with school districts, parents and parent associations, San Diego County Office of Education, local law enforcement agencies, HHSA-Alcohol and Drug Services, substance abuse prevention agencies, auto insurance companies, and media partners to:

1. Work toward passage of state legislation to restore driver education in schools.
2. Provide education to parents about the dangers of "social host" parties for youth and enforce penalties on adults who provide alcohol to youth.
3. Encourage youth involvement in local programs such as *Friday Night Live*, *Club Live*, sports and recreation programs, after school programs, and so forth.



“Motor vehicle crashes are not ‘accidents,’ and much can be done to prevent them and the injuries that result.” David Satcher, former U.S. Surgeon General

Ages 13–18 (Adolescence):

MOTOR VEHICLE CRASHES INVOLVING YOUTH DUI

What is the indicator?

The rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population.

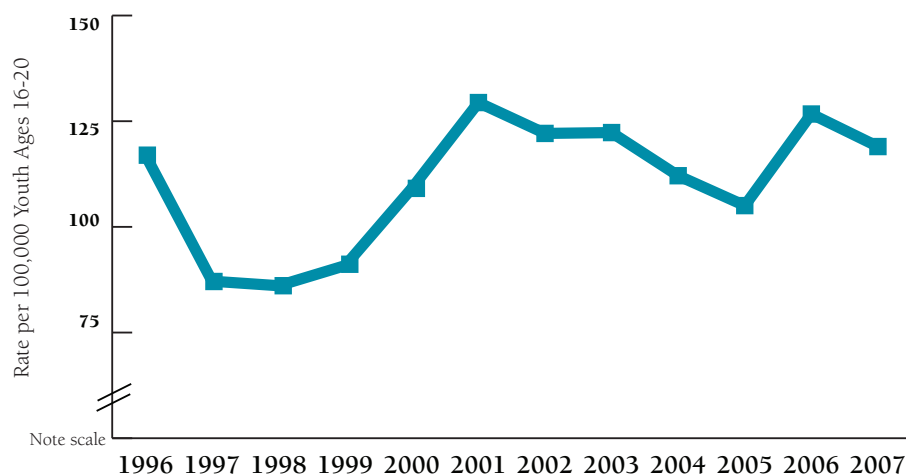
This indicator — the rate of fatal and non-fatal crashes involving drivers ages 16-20 under the influence of alcohol or drugs per 100,000 population in this age group — shows the extent to which our youth are drinking, driving, and crashing resulting in injury and death. Alcohol and drug involved means that at least one of the drivers involved in the crash had been drinking and/or using drugs. These data come from the Statewide Integrated Traffic Records System (SWITRS).

Why is this important?

Teenagers in the U.S. have higher motor vehicle crash rates than adults, and the results are serious. Motor vehicle crashes are the leading cause of death for 15-to-20 year olds in the United States, accounting for about one-third of all teen deaths. Driving under the influence of alcohol and drugs is often a factor in these crashes. Young men 18-20 report driving under the influence more than any other age or gender group. They are nearly twice as likely to have accidents, and to die in these accidents. Teens are more likely to have passengers in their cars when they crash, presenting a danger both to themselves and others. The true tragedy of these crashes is that they are highly preventable.

How are we doing?

Rate of Non-Fatal Crashes Involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 1996-2007



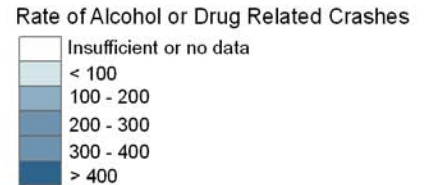
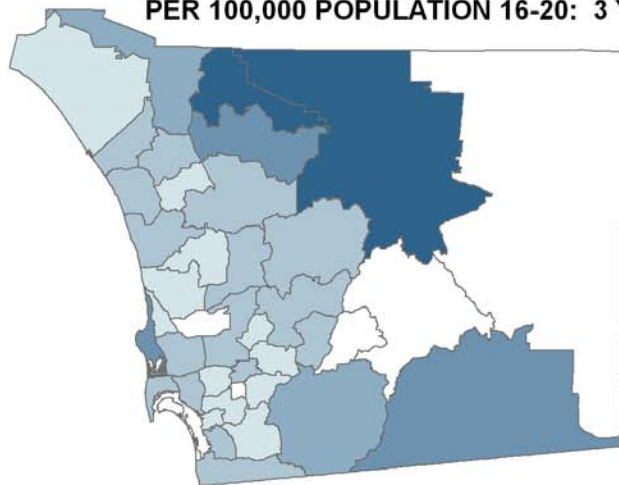
The trend is not improving. Despite fluctuations year to year, the rate of alcohol- and drug-related crashes among drivers ages 16-20 is at the same level as in 1996, over a decade ago. Youth continue to use drugs and alcohol and operate motor vehicles, and they had 295 DUI related crashes in 2007.

Rate of Fatal Crashes Involving Drivers Ages 16-20 Under the Influence of Alcohol or Drugs, Per 100,000 Population, San Diego County, 1996-2007



The trend is improving overall. The rate of fatal crashes in 2007 was the lowest in a decade.

LOCATIONS OF ACCIDENTS INVOLVING DRIVERS AGES 16-20 USING ALCOHOL OR DRUGS PER 100,000 POPULATION 16-20: 3 YEAR AVERAGE 2004-06



Overall County Rate 119

NOTE: Data from California Department of Motor Vehicles, Statewide Integrated Traffic Records System 2004-2006. Crashes involving drivers ages 16-20 who had been drinking or using drugs. Data prepared by County of San Diego Public Health Services, Emergency Medical Services. Rates calculated using SANDAG 2004-2006 demographic estimates.

The areas in which the highest rate of drug- and alcohol-related crashes occur are in the rural mountain areas of San Diego County, including Pauma, Santa Ysabel, and Warner Springs. Note this map uses three-year average for 2004-06.

What strategies can make a difference?

Helping youth make the right decisions about both drinking and driving is critical but difficult, as concerned parents/citizens are not typically present when these decisions are made. Therefore, we need to prepare our youth ahead of time to make a safe decision. Current strategies use education, legal restrictions and consequences, and support to combat youth drinking and driving.

The following strategies have been used to reduce DUI and related crashes:

- Providing quality driver education and training lasting at least three months.
- Implementing graduated driver licensing that includes a mandatory waiting period, nighttime driving restriction, at least 30 hours of supervised driving, and passenger restriction.
- Limiting youth driving privileges during the first 12 months with a new license, the most dangerous period. Crash rates are the highest for the first 6 months and 1,000 miles of driving, regardless of other factors.
- Educating youth about the risks of riding in a car when a driver has been drinking.
- Instituting community and school-based programs to maintain student and parent awareness about the dangers of drinking and driving.
- Targeting sobriety checkpoints in communities with highest incidences of alcohol- and drug-related accidents.
- Prohibiting wireless telephone use (even hands free) and “texting” among youth while driving.
- Enforcing mandatory seat belt laws.
- Maintaining a legal drinking age of 21.

How can we improve the trend in San Diego County?

San Diego and California have already implemented several best practices in preventing youth DUI, such as graduated driver licensing, increased DUI penalties, prohibitions on cell-phone use and texting while driving, school-based education programs, and sobriety checkpoints on holidays. In 2006, The Children’s Initiative partnered with the California Department of Motor Vehicles to identify where youth live who are drinking, driving, and crashing, with the the goal of designing interventions for communities.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with local law enforcement agencies, school districts, parents and parent associations, driver education providers, businesses and business associations, automobile insurance companies and substance abuse prevention agencies to:

1. Focus on effective and affordable driver training, by requiring that behind-the-wheel training be provided by an accredited driver’s training provider and reinstating driver education training courses in schools.
2. Conduct sobriety checkpoints in communities of residence of the youth with the highest incidence of youth alcohol- and drug-related motor vehicle crashes.
3. Assist parents in their efforts to limit youth driving privileges in the first 12 months.



“Research is clear that poverty is the single greatest threat to children’s well-being.”

National Center for Children in Poverty

Community and Family (Cross Age): **POVERTY**

What is the indicator?

The percent of children age 0-17 living in poverty.

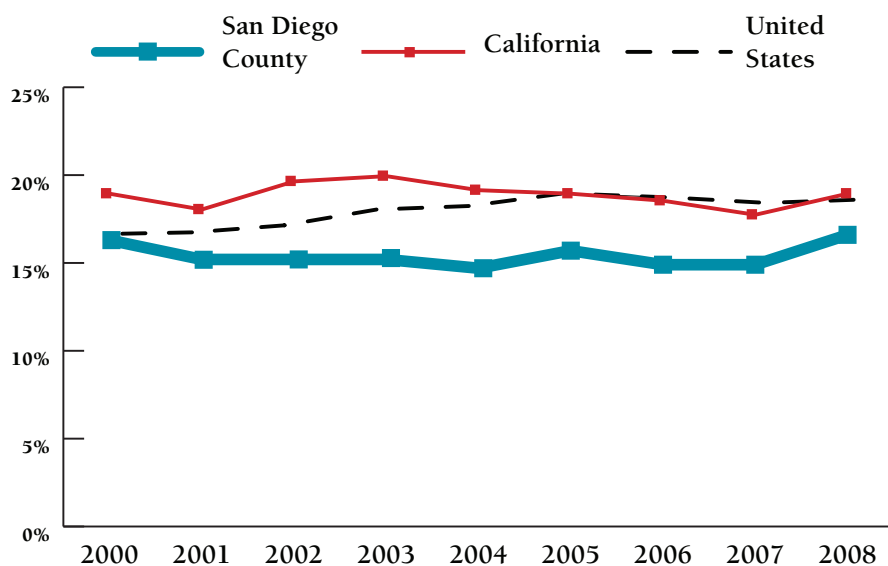
The indicator is the percent of children under age 18 living below 100 percent of the Federal Poverty Level. The Federal Poverty Level was set at an annual income of \$22,050 for a family of four in 2009. In San Diego and California, the level of income sufficient to meet basic expenses such as housing and food is closer to 200 percent of poverty (\$44,100). The data are routinely reported by the U.S. Census Bureau and SANDAG. Data on income by region comes from California Health Interview Survey.

Why is this important?

Living in poverty puts children at increased risk for a range of problems. The “dose” of poverty matters, that is, the more severe the poverty or more years a child lives in poverty, the worse the outcomes. Poor children are disproportionately exposed to risk factors that may impair brain development and affect social and emotional development. Exposures may include environmental toxins, inadequate nutrition, maternal depression, parental substance abuse, trauma, abuse, violence, and low quality education and child care. Adolescents in poor families are more likely to engage in risky behaviors, including smoking, early initiation of sexual activity, drug and alcohol abuse, and delinquent behaviors.

How are we doing?

**Percent of Children Ages 0-17 Living in Poverty,
San Diego County, California, and United States, 2000-2008**



While the San Diego County poverty rate generally decreased slightly in recent years, it increased substantially between 2007 and 2008. The child poverty rate of 16.6 percent in 2008 was the highest for San Diego County since 2000.

What strategies can make a difference?

Many factors affect families' income and poverty status. In the current economic recession, many families with children are among the newly poor; other families who were already poor have been even harder hit. Government programs and subsidies for low-income working families—such as earned income tax credits, child care subsidies, health insurance, Food Stamps, and housing assistance—can help families move out of poverty. Such benefits encourage, support, and reward work by helping families close the gap between low wages and basic expenses. Other effective practices address family, cultural, neighborhood, educational, and job skill components. More than a decade of research shows that increasing the incomes of low-income families—without any other changes—can positively affect children's health and development, especially for younger children.

The following strategies have been used across the country to impact poverty:

- Focusing “welfare to work” programs on barriers to employment such as low education, poor work history, substance abuse, and domestic violence.
- Encouraging families to use federal and state Earned Income Tax Credits (EITC), a refundable tax credit for low-income individuals and families using federal income tax returns. According to the U.S. Government Accountability Office (GAO), 15 to 25 percent of qualified working families do not file to get their refunds/credits.
- Increasing parents' access to literacy, post-secondary, and vocational education.
- Providing free and low-cost job training and GED courses for working parents.
- Providing child care at education and training sites.
- Increasing community-wide levels of education achievement and reducing dropouts.
- Assisting families to open an Individual Development Account (IDA) to help them get bank accounts, save money, and accumulate assets.
- Offering Individual Training Accounts (ITA), as established under the Workforce Investment Act, to help eligible individuals finance job-related education and training. ITAs act like a voucher that can be exchanged for training at an approved learning institution.

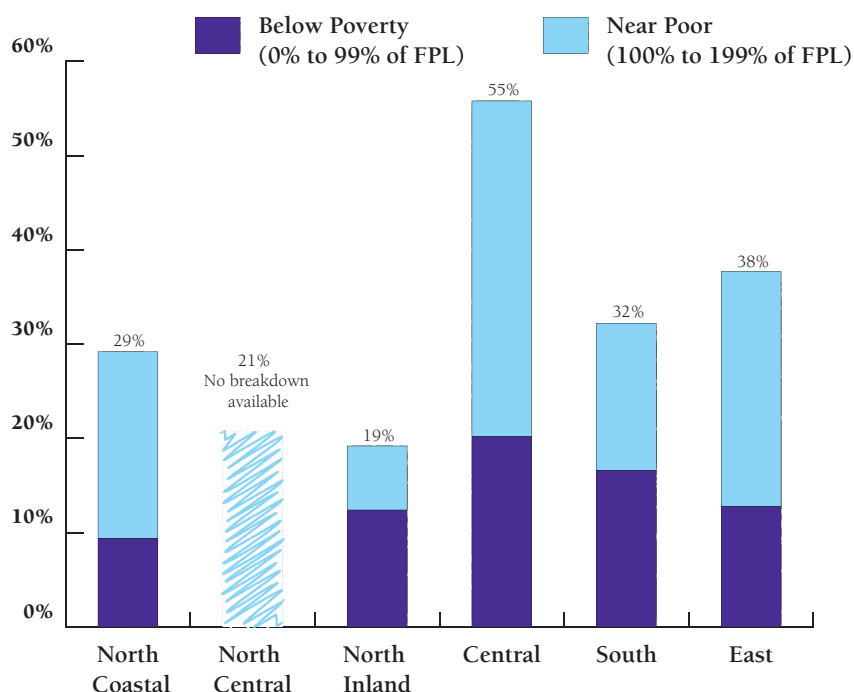
How can we improve the trend in San Diego County?

The San Diego Workforce Partnership committed \$250,000 for youth ITAs and \$5.6 million to ITAs for adults in 2009-2010. County Office of Education offers IDAs and financial literacy training to current or former foster youth. The San Diego Housing Commission also offers IDAs.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the San Diego Workforce Partnership, community development corporations, schools, community colleges and universities, community-based organizations, faith communities, United Way of San Diego County, 211, Chambers of Commerce, mental health providers, HHSA-Behavioral Health Services, and HHSA-Alcohol and Drug Services to:

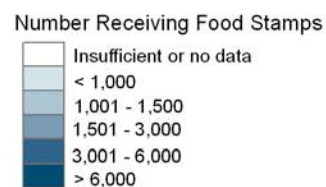
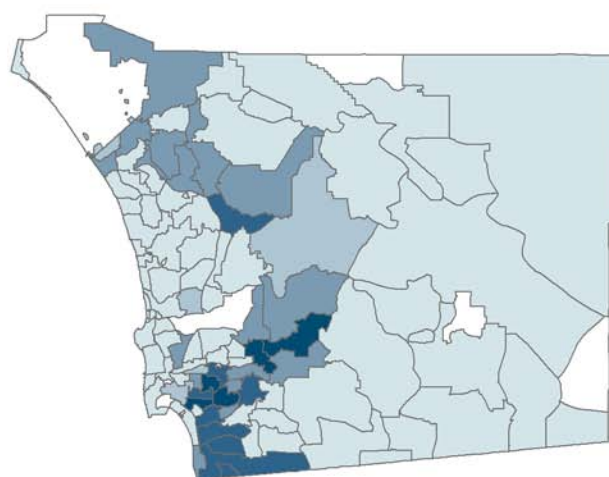
1. Provide outreach to assure families who have become unemployed or underemployed have knowledge and access to apply for public assistance such as unemployment, income, health, and housing benefits, as well as job training and educational opportunities.
2. Expand services such as financial planning, education, job placement, and skill training for parents and youth in poor and near-poor families.
3. Provide information and assistance through the San Diego Workforce Partnership network of providers to help families effectively use the EITC, IDAs, and ITAs to improve their economic status.

Percent of Children Living in Low-Income Households, By Poverty Level and Region, San Diego County, 2007



In parts of San Diego County, one-third to one-half of children are living in low-income households, earning below 200 percent of the federal poverty level.

NUMBER OF FOOD STAMP RECIPIENTS: JULY 2009



Total Recipients 145,114

NOTE: Data from CalWIN MRH007E & MR009E, July 2009.

The highest number of food stamp participants are in Central San Diego, zip code 92105. This is consistent with the greater number of low-income individuals who live in the central city area.



“One of the most disturbing and extraordinary aspects of life in this very wealthy country is the persistence of hunger.” Food Research and Action Center

Community and Family (Cross Age): FOOD STAMPS

What is the indicator?

The number of children ages 0-17 receiving Food Stamps.

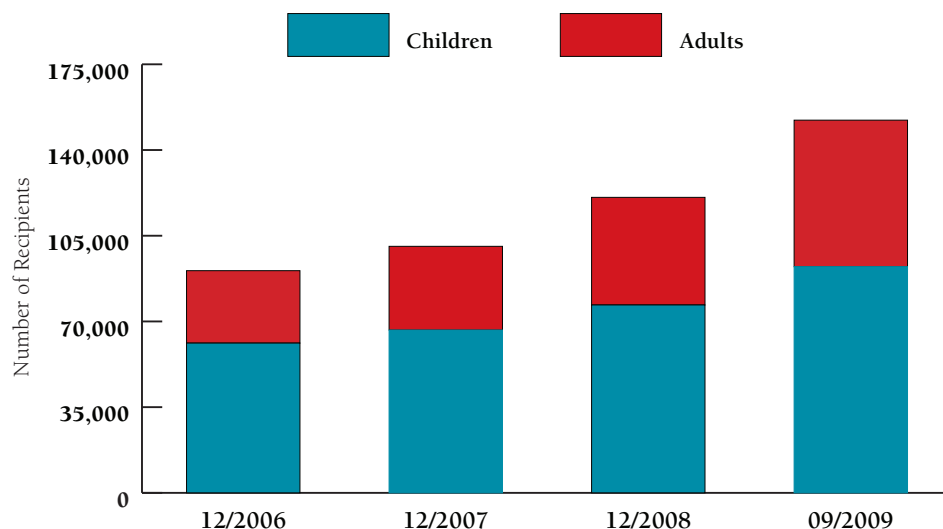
This indicator — the number of children ages 0-17 receiving Food Stamps — documents how many eligible San Diego County children are participating in the federal Supplemental Nutrition Assistance Program (SNAP). This information is collected through the Health and Human Services Agency CalWIN program. The rate of eligible people using the program — participant access rates or PARS — is calculated by the USDA Food and Nutrition Service and reported by the Food Resource and Action Center.

Why is this important?

Sufficient food is one of humanity’s most fundamental needs. As an economy worsens, more people go hungry. The federal Food Stamp program, now called Supplemental Nutrition Assistance Program or SNAP, is one of the simplest and most effective ways to get food to those in need. The combined use of Food Stamps and Earned Income Tax Credit can lift a family of four with one minimum wage earner to reach or even surpass the poverty line; without these benefits, such a family would live in extreme poverty. Another benefit of Food Stamps is the ability to quickly meet nutrition needs in emergency or suddenly changing economic situations.

How are we doing?

Number of Food Stamp Recipients, Children Ages 0-18 and Adults, San Diego County, 2006-2009



Since 2006, San Diego County substantially increased the number of eligible children receiving food assistance through SNAP, as have the state and nation. Still, our county has the lowest participation rate of any large urban area in the nation, with only 35 percent of eligible households participating in 2007.

What strategies can make a difference?

Although Food Stamps are an effective aid to improve the nutritional status of low-income families, utilization rates are traditionally low. Successful strategies to improve access and utilization rates involve outreach campaigns, multiple agency involvement, and creative points of access. Increased use of Food Stamps means better nutrition for families, dividends for states, and a way for families to connect to other nutritional resources.

Nationally, the following strategies have been used to increase Food Stamp participation.

- Simplifying on-line and paper application processes.
- Providing outreach and enrollment centers in targeted and rural communities.
- Extending hours (e.g., evenings and weekends) in application centers.
- Using multi-lingual staff.
- Increasing outreach partners such as food banks, tax preparers, and utility companies.
- Reaching out to underserved populations such as veterans, AIDS patients, Native Americans, immigrants, seniors, and persons with disabilities.
- Providing assistance in completing applications.
- Creating a welcoming environment in application offices.
- Conducting a public awareness/education campaign.
- Stationing outreach and enrollment workers in community settings, treatment settings, and shelters.
- Including Food Stamp information and prescreening in community hotlines and helplines.

How can we improve the trend in San Diego County?

In a quick response to the economic downturn, the HHSA convened Thrive San Diego, a collaborative public-private partnership with key organizations including the United Way of San Diego County, San Diego Foundation, Internal Revenue Service (IRS), 211, universities, and community agencies to form an action plan to reach out to needy families with assistance in enrolling in Earned Income Tax Credit (EITC) and Food Stamp assistance. Initial plans include training university students to provide tax assistance and financial education to families as well as prescreening for SNAP enrollment, enhancing 211 outreach and local access, and partnering with San Diego Workforce Partnership to expand financial opportunities through paid work experience.

Based on what works and what we have been doing, the top three recommendations for San Diego are to work with self-sufficiency programs, family resource centers, faith communities, the United Way of San Diego County, 211, San Diego Food Bank, schools, local universities, HHSA, San Diego Hunger Coalition, San Diego Workforce Partnership, community-based organizations, and California Department of Social Services to:

1. Expand outreach in community settings and streamline and simplify the application process through interagency efforts.
2. Support 211's expansion to local communities and development of prescreening capability through their hotline.
3. Conduct a public awareness/education campaign to educate eligible families about eligibility for Food Stamps.



“Everyone — individuals, businesses, nonprofits, and government — can play a role and has a responsibility to work toward achieving a healthier future for all our citizens, and especially for our youngest, most vulnerable members.” Jennifer L. Howse, President, March of Dimes

Community and Family (Cross Age): HEALTH COVERAGE

What is the indicator?

The percent of children ages 0-17 who are without health coverage.

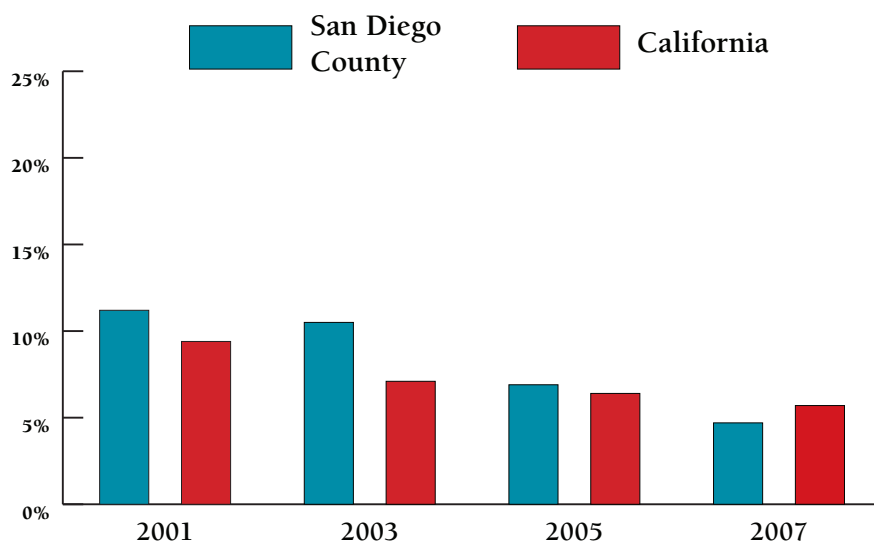
This indicator monitors the percent of children who are without health coverage in San Diego County. This information is collected every other year and reported through the California Health Interview Survey.

Why is this important?

The single greatest barrier to receiving medical care is lack of health coverage. Uninsured children are less likely than their insured counterparts to receive preventive services and needed interventions for problems. For children with special health care needs (those with chronic conditions that typically require extra care and treatment), lack of coverage can mean more hospitalizations for untreated asthma, poorly treated vision or hearing problems, and worsening disabilities. Thirty years of research has shown that children with publicly subsidized health coverage (e.g., Medi-Cal) use services in approximately the same amounts and patterns as those who have private insurance.

How are we doing?

**Percent of Children Ages 0-17 without Health Coverage,
San Diego County and California, 2001, 2003, 2005, and 2007**



San Diego continues to show substantial improvement in rate of health coverage for our children, surpassing state levels in 2007.

What strategies can make a difference?

With expansions of Medicaid (known as Medi-Cal in California) and the Children's Health Insurance Program (CHIP, known as Healthy Families in California), most children with family income below 200 percent of the Federal Poverty Level are eligible for publicly subsidized coverage when no employer-based coverage is available to them. Additionally, the initiation of the Kaiser Child Health Plan for children with family income up to 300 percent of the Federal Poverty Level has helped to decrease the number of uninsured children. Assuring that families know that such coverage is available and simplifying eligibility is essential. New federal law, signed by President Obama in 2009, emphasizes use of effective strategies to improve outreach and enrollment, particularly for children who are eligible but remain uninsured.

The following strategies have been used across the country to increase health coverage for children:

- Developing effective outreach and enrollment strategies such as those used in the “Covering Kids” projects at the state and community level across the country, including:
 1. Campaigns to promote awareness of available coverage (e.g., culturally specific marketing tools, outreach through employers, billboards and posters).
 2. Assistance in distributing and completing applications in schools and the workplace.
 3. Incentives for schools, employers, and community-based organizations to identify families and help them enroll their children.
- Simplifying and streamlining the application process and enrollment policies (e.g., shortening forms, accepting applications by mail or Internet, eliminating asset tests, eliminating the need for initial fee with the Healthy Families application).
- Using federally required outreach workers at locations such as community clinics.
- Expanding publicly subsidized health insurance to low-income and uninsured parents.

How can we improve the trend in San Diego County?

California and San Diego have taken action to help assure continued health coverage for children. In September 2009, California enacted legislation that prevented 700,000 children from losing their Healthy Families coverage. The protection will be financed by a tax on health plans, funds from First 5 California, and leveraging federal matching funds. The First 5 San Diego Healthcare Access Initiative enrolls eligible children ages 0 through 5 and pregnant women in health insurance programs — Healthy Families, Medi-Cal and Access for Infants and Mothers (AIM) — and assists families in maintaining their insurance and appropriately utilizing medical care.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with First 5 San Diego, health providers, health plans, family resource centers, parents and parent associations, 211, San Diego Workforce Partnership, Chambers of Commerce, California Department of Health Services, Health and Human Services Agency, faith communities, and community-based organizations to:

1. Provide outreach to assure families who have become unemployed or underemployed have knowledge and access to apply for Medi-Cal and Healthy Families coverage.
2. Work toward a permanent resolution to the budget challenges that face Healthy Families.
3. Expand use of federally required outreach and eligibility workers at locations such as community clinics and WIC offices, as well as Certified Application Assistors (CAA) and application support in schools.



“Witnessing violence between one’s parents or caretakers is the strongest risk factor of transmitting violent behavior from one generation to the next.” National Coalition Against Domestic Violence

Community and Family (Cross Age): DOMESTIC VIOLENCE

What is the indicator?

The rate of domestic violence reports per 1,000 households.

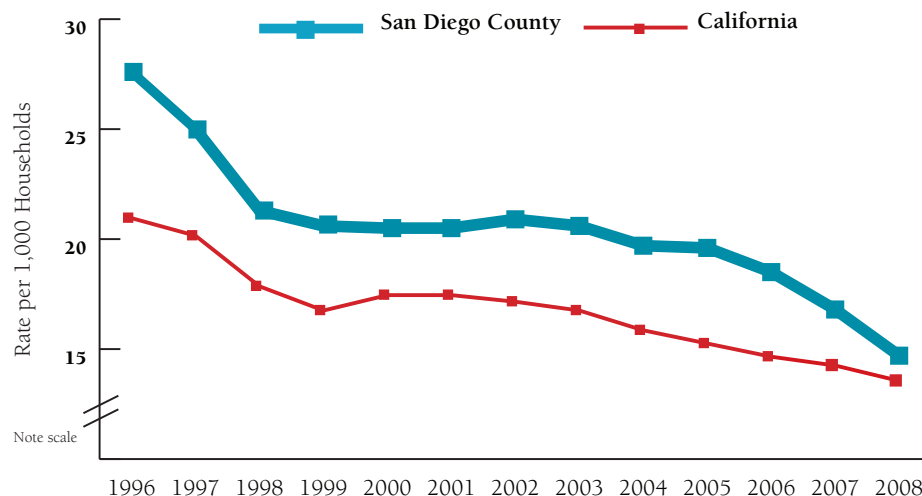
This indicator — the rate of domestic violence reports per 1,000 households — documents the rate of reports of domestic violence and intimate partner violence made to San Diego County law enforcement agencies. The rate of police reports is generally closer to the actual rate at which violence is occurring than is the number of arrests or convictions made. The number of reports is considered to be an under-estimate, as many incidents go unreported. These data are collected and reported by ARJIS.

Why is this important?

Domestic violence affects everyone involved, either directly or through exposure to violence. The abused partner may suffer both physical and emotional trauma, as well as post-traumatic stress. Domestic violence typically escalates over time, moving from verbal abuse to emotionally abusive behavior, to physical abuse, and can result in death. Exposed children live in fear and hopelessness. They often perform poorly in school, and typically do not participate in normal childhood play and social activities. Children who have these adverse, violent experiences — even when the violence is not directed at them — have increased risk of victimization, aggression, problems with social relationships, and lifelong health problems.

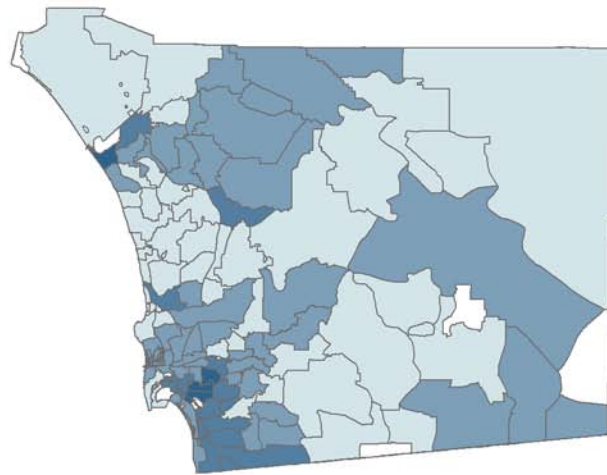
How are we doing?

**Rate of Domestic Violence Reports Per 1,000 Households,
San Diego County and California, 1996-2008**

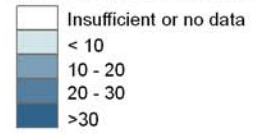


The trend is improving. The rate of domestic violence reports is declining in San Diego County. The county rate has consistently been worse than the state average, however.

RATE OF DOMESTIC VIOLENCE INCIDENTS PER 1,000 HOUSEHOLDS: 2008



Rate of Domestic Violence



Overall County Rate	14.7
California State Rate	15.2

NOTE: Data from Automated Regional Justice Information System, ARJIS. Data prepared by County of San Diego Health and Human Services Agency with assistance from the District Attorney's Office. Rates calculated using SANDAG 2008 Household Estimates.

The highest rates of domestic violence reports are in Central San Diego (specifically in zip codes 92102, 92105 and 92113) and in Oceanside. Some neighborhoods have rates more than twice the county and state averages.

What strategies can make a difference?

The following strategies have been used across the country to reduce the incidence of domestic violence:

- Screening routinely for domestic violence and child abuse in health care settings, with follow up referrals as necessary.
- Using cross-system reporting of child abuse and domestic violence to increase consistency (e.g., in filing Suspicious Injury and Suspected Child Abuse reports).
- Educating judges about domestic violence to ensure consistency in sentencing.
- Coordinating divisions of the court system (e.g., criminal, juvenile, family, civil).
- Assuring enforcement of perpetrators' mandated treatment, including monitoring of active participation in yearlong violence prevention programs and other terms of probation.
- Assuring the removal/submission of firearms in households where domestic violence occurs.
- Creating "no wrong door" policies and procedures for victims (e.g., through hotlines and mental health systems).
- Using school and youth programs to raise awareness about healthy relationships and the risk of teen dating violence and to provide resources to support youth.
- Boosting training for staff that work with families experiencing abuse.
- Updating regularly the protocols and policies, including cross-system protocols, related to domestic violence and intimate partner violence.
- Helping victims develop and continually update their safety plans.
- Providing evidence-informed trauma-focused therapy and related services.
- Developing well-trained advocates available to assist victims and their families.
- Providing readily accessible services (e.g., shelters, legal assistance, counseling, case management) for victims and their children.

How can we improve the trend in San Diego County?

San Diego has been working across systems and agencies, and with communities, to develop and implement a countywide system of care for children and families exposed to domestic violence. Efforts include Raising the Bar, a countywide project to develop region-specific plans for a comprehensive continuum of care for children and families exposed to violence, and Safe Start, a trained, cross-system team working directly with children in the child welfare system that have been exposed to domestic violence. Based on the work of the Children's Initiative, the DV Supplemental form for law enforcement reporting has been standardized countywide. For the first time, this form now collects data on the number of children living with either the suspect or victim of domestic violence. In February, 2009, every law enforcement jurisdiction (over 5,000 sworn personnel) received related training. The San Diego Domestic Violence Council developed a Subcommittee on Children Exposed to Domestic Violence and Child Abuse to address the intersection between child abuse and domestic violence.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with the HHSA-Office of Violence Prevention, law enforcement agencies, HHSA-Public Health, courts, schools, faith communities, HHSA-Behavioral Health Services, mental health providers, HHSA-Alcohol and Drug Services, health providers, and other service providers to:

1. Increase cross-system training in identification, screening, and assessment of domestic violence (e.g., public health nurses, teachers, mental health providers, alcohol and drug counselors).
2. Increase the use of routine developmental screening in early childhood (with objective tools) to increase the identification of young children exposed to violence and other trauma.
3. Improve access to culturally and linguistically appropriate services and supports for victims, batterers, and their children.



“Early childhood exposure to adversities such as child abuse or neglect increases the risk of lifetime physical and mental health consequences.” Centers for Disease Control and Prevention

Community and Family (Cross Age): CHILD ABUSE AND NEGLECT

What is the indicator?

The rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17.

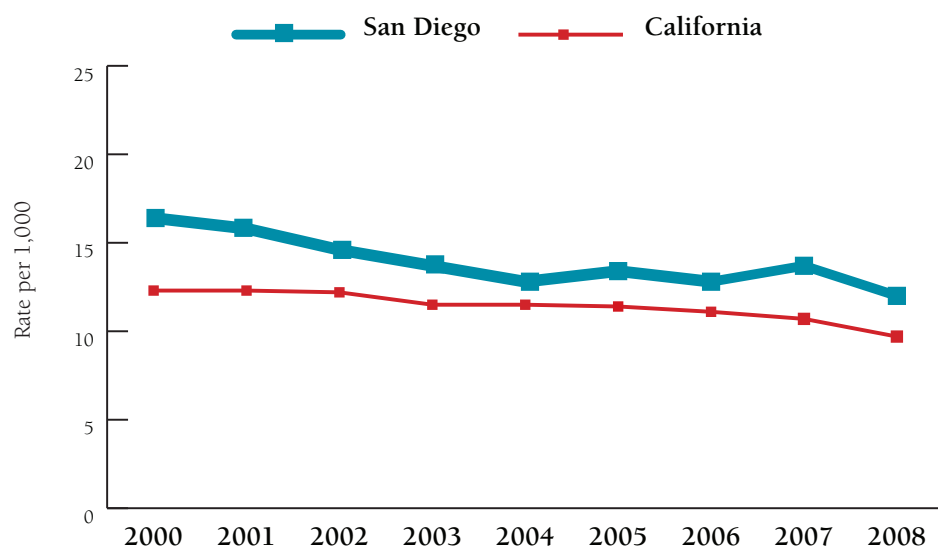
This indicator — the rate of substantiated cases of child abuse and neglect per 1,000 children ages 0-17 — shows the trend in reports of child abuse and neglect that are found through investigation to have sufficient evidence to warrant a child welfare services case being opened or having the family referred for services. These data come from reports filed by our county’s HHSA-Child Welfare Services to a state database managed by the University of California Berkeley.

Why is this important?

Child abuse and neglect has serious and permanent consequences for a child’s physical, emotional, and mental health, and even cognitive development. Physical effects include injury, disability, and even death. Psychological effects include depression, anger, self-harm behaviors, anxiety, and aggression. Cognitive issues include impaired brain development. Abused and neglected children often have social and behavioral problems, and research shows that they are less likely to succeed in school. Children who suffer neglect are often deprived of food, clothing, and shelter—the basic necessities of life. Recent attention has also been drawn to shaken baby syndrome and related deaths.

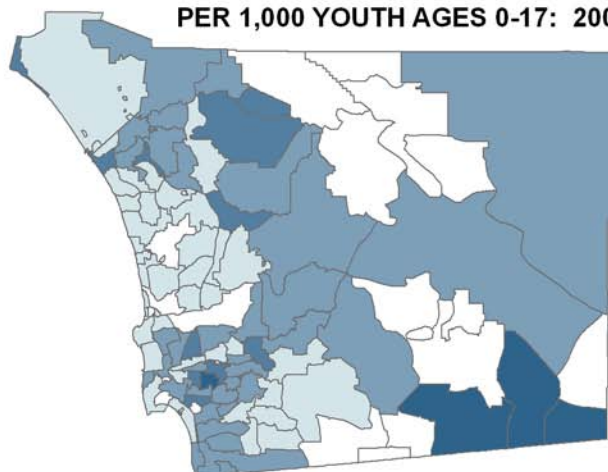
How are we doing?

Rate of Substantiated Cases of Child Abuse and Neglect Per 1,000 Children Ages 0-17, San Diego County and California, 2000-2008



The San Diego County rate of substantiated reports of child abuse and neglect continues to decline and is approaching the state average.

RATE OF SUBSTANTIATED REFERRALS OF CHILD ABUSE & NEGLECT PER 1,000 YOUTH AGES 0-17: 2007



Rate of Substantiated Referrals

- Insufficient or no data
- < 10
- 10 - 20
- 20 - 30
- > 30

Overall County Rate	13.7
California State Rate	10.7

NOTE: Data from Child Welfare Services Case Management System (CWS/CMS), Childrens Research Center (CRC), SANDAG 2007 demographic estimates. Rates have been rounded and vary slightly from previous years due to adjustments of population estimates. Rates do not include referrals with invalid or unknown zip codes (average 1.5% of referrals).

The highest rate of substantiated reports of child abuse and neglect are in Central San Diego in zip code 92105. Note that map shows rates for 2007, the latest year data are available at the zip code level.

What strategies can make a difference?

Child abuse is associated with many factors, including parental substance abuse, unemployment, poverty, history of abuse, domestic violence, anger, isolation, mental health problems, stress, and cultural beliefs. Effective interventions should be tailored to the individual situation. The Adverse Childhood Events (ACE) studies show that child abuse and neglect can have a lifelong impact on health and well-being, including increased risk of heart disease, obesity, and depression as an adult.

The following strategies have been used to reduce the incidence of child abuse and neglect:

- Developing parent support groups and parenting classes teaching age-appropriate communication, expectations, and intervention, beginning in early childhood.
- Providing family training to improve parent-child relationship skills and increasing social supports for at-risk families.
- Providing quality home visiting programs for families at risk prenatal to three years.
- Implementing the SafeCare model, an intensive, evidence-based home visitation program focused on children from birth to 12 years old that has been shown to reduce child abuse and neglect among families with a history for maltreatment.
- Using efforts such as “Period of PURPLE Crying”® (an evidence-based shaken baby syndrome prevention program) to help parents and other caregivers.
- Implementing the Positive Parenting Program (Triple P) shown to be effective in prevention of childhood social-emotional and behavioral problems and child maltreatment.
- Providing respite care for high-stress and emergency situations.
- Using the court to identify and “sentence” families to treatments and interventions designed to reduce abuse and neglect.
- Offering intensive family training to improve parent-child relationship skills for families with identified problems.
- Training health providers, teachers, and other care providers to recognize signs of abuse and neglect, as well as providing information regarding community resources available.

How can we improve the trend in San Diego County?

First 5 San Diego funded universal Newborn Home Visiting for families with recent births, and currently this program is transitioning towards targeted home visiting services for families identified as at risk. SafeCare has been implemented in the San Diego region with the support of United Way of San Diego County, with more than 100 families served to date. Additionally, United Way introduced the Period of PURPLE Crying program to 15 organizations, and SANDAPP was nationally recognized for use of the Period of PURPLE Crying program with teen parents.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with HHSA-Child Welfare Services, United Way of San Diego County, First 5 San Diego, parents and parent associations, schools, the courts, HHSA-Behavioral Health Services, mental health providers, community-based organizations, and faith communities to:

1. Expand intensive home visiting for vulnerable families.
2. Implement a continuum of evidence-based programs for parents, from those designed to promote positive parenting practices to those that address child maltreatment and abuse.
3. Expand and sustain effective in-home support and intervention programs such as Therapeutic Behavioral Services, Community Assessment Teams, and wraparound services.



“Safety and security don’t just happen: they are the result of collective consensus and public investment.” Nelson Mandela

Community and Family (Cross Age): CHILD VICTIMS OF VIOLENT CRIME

What is the indicator?

The rate of violent crime victimization per 10,000 children or youth ages 0-11 and 12-17.

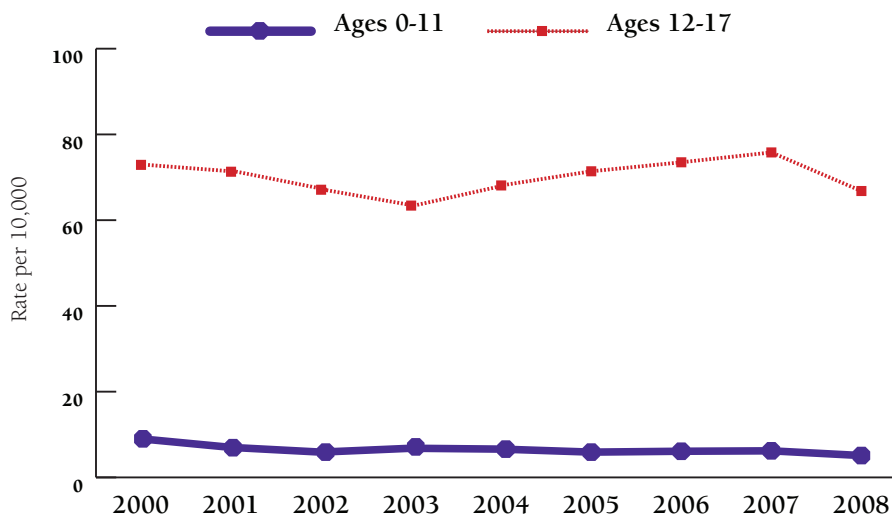
This indicator — the rate of violent crime victimization of children — reflects trends in four types of crime (homicide, rape/sexual assault, aggravated assault, robbery by force or threat). The data are from ARJIS, so only those incidents that result in an arrest report are represented. In future Report Cards, data from the Emergency Medical Services and pre-hospital reports may be available to monitor incidents that do not result in an arrest.

Why is this important?

Violent crimes perpetrated against children are a tragedy that impacts lives forever, altering trust, development, mental health, and success in school. Nationally, children and adolescents are most likely to be victims of violent crime overall. According to the National Crime Victimization Survey, teenagers are two to three times more likely than adults to be the victims of assault, robbery, or rape. Most female victims are attacked by someone they know, typically by adult men. Children are also victims of crimes specific to their age status, such as sexual abuse and family abduction. Victimized children are at risk for post-trauma impacts such as emotional, behavioral, and academic problems.

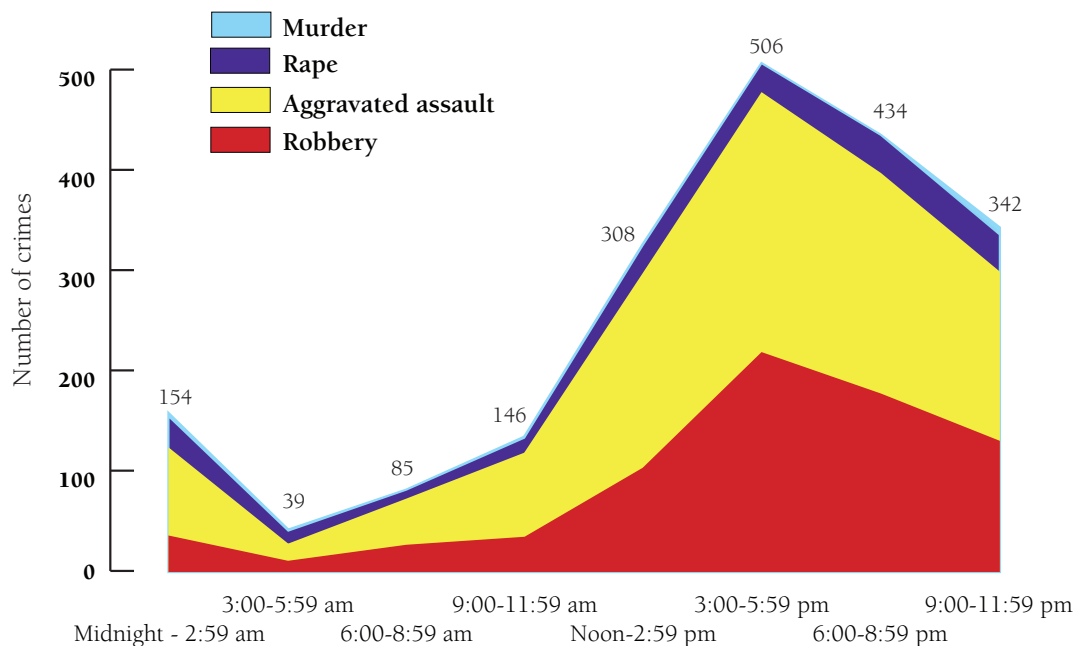
How are we doing?

Rate of Violent Crime Victimization Per 10,000 Children,
Ages 0-11 and 12-17, San Diego County, 2000-2008



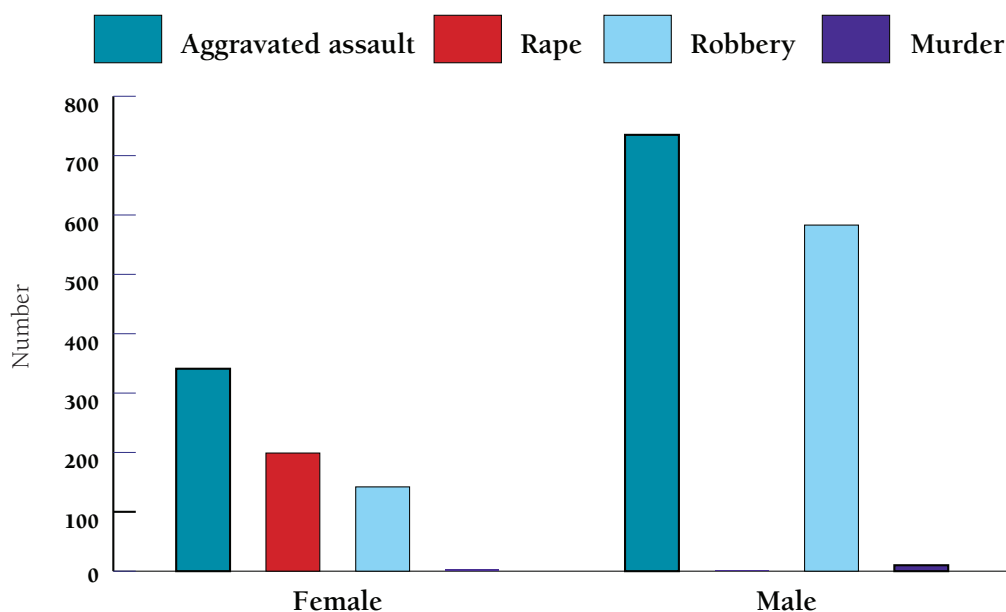
The overall trend is maintaining. The rate for both age groups declined somewhat in 2008; however, this did not represent a substantial decline in the overall trend.

Number of Violent Crimes with Child Victims Ages 0-17, By Time of Day, San Diego County, 2008



The number of violent crimes committed against children and youth increases dramatically after school peaking between the hours of 3 pm and 6 pm.

Number of Children Ages 0-17 Who were Victims of Violent Crime, By Type of Crime and Gender of Victim, San Diego County, 2008



The largest share of crimes against children were against boys, particularly aggravated assault and robbery. The pattern is different for girls, who reported half the total number of crimes as boys. Female victims also are more likely to experience rape, although rapes against males are reported.

What strategies can make a difference?

The following strategies have been used across the country to reduce violent crime victimization of children and youth:

- Implementing effective school-wide behavior policies and codes of conduct.
- Developing school anti-violence and anti-bullying prevention programs such as: Olweus Bullying Prevention, PeaceBuilders, Promoting Alternative Thinking Strategies (PATHS), and Resolving Conflict Creatively Program (RCCP).
- Educating parents, caregivers, and youth-serving organizations about Internet safety programs including monitoring and restriction of use and Internet controls.
- Implementing conflict resolution programs in schools, after school programs, and in youth-serving community organizations.
- Implementing gender specific services for girls.
- Expanding programs aimed at reducing gang participation.
- Training parents, school personnel, after school staff, youth-serving organizations, and community clinics in the identification and prevention of bullying, intimidation, and sexual harassment.
- Supporting safe passages for children and youth to and from school.
- Increasing youth (especially girls) and parent knowledge of and ability to protect against sexual assault and rape.
- Raising awareness among youth and adults about the importance of reducing crime.

How can we improve the trend in San Diego County?

The Juvenile Justice Coordinating Council and Juvenile Justice Comprehensive Strategy Task Force are oversight bodies that insure that service providers work collaboratively to reduce violent crime in our region. Local juvenile justice programs show positive exit outcomes such as increased resiliency, reduced recidivism, better school attendance and grade point averages, and reduced positive drug screenings. Schools play an equally important role in reducing violence and bullying among children and youth.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with schools and school districts, San Diego County Office of Education, parents and parent associations, community-based organizations, faith communities, community centers, neighborhood associations, municipalities, law enforcement, the courts, and Probation Department to:

1. Expand anti-violence and anti-bullying programs in schools, after school programs, youth-serving community centers, community-based organizations, and juvenile detention facilities.
2. Support “safe passage” from home to school in communities with highest incidence of violent crime involving children.
3. Increase education and programs for girls that promote youth development, physical safety, self-confidence, and assertiveness.



“Injuries have physical, emotional, and financial consequences that can impact the lives of individuals, their families, and society.” Centers for Disease Control and Prevention

Community and Family (Cross Age): UNINTENTIONAL INJURY HOSPITALIZATIONS AND DEATHS

What is the indicator?

The rate of unintentional injuries per 100,000 children ages 0-18.

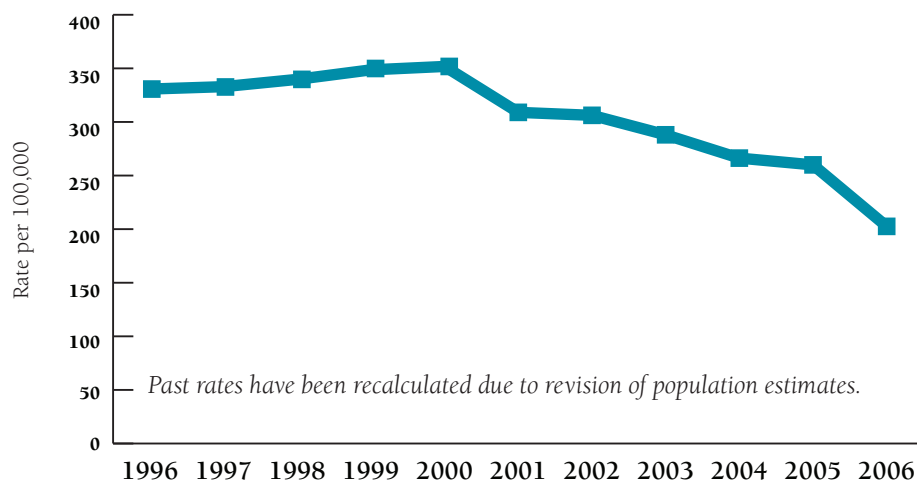
This indicator — the rate of hospitalized and fatal unintentional injuries per 100,000 children 0-18 — shows trends in how many children are injured sufficiently to require hospitalization or who die of accidental causes. These data are routinely reported on hospital discharge reports and death certificates.

Why is this important?

As a group, unintentional injuries are the leading cause of death for children. Unintentional injuries and related deaths of children have a lasting negative impact on families. Parents and siblings suffer for years over such losses. These injuries cost society millions in lost productivity and associated medical expenses. The true tragedy of these injuries and deaths is that they are largely preventable.

How are we doing?

**Rate of Fatal and Non-Fatal Unintentional Injuries per 100,000
Children Ages 0-18, San Diego County, 1996-2006**



The trend is improving. The rate of unintentional injuries to children has decreased steadily since 1996.

What strategies can make a difference?

While unintentional injuries are the leading cause of death it is important that each cause be addressed individually. Specific prevention and intervention approaches may be needed for each cause. Legal mandates and public education about safety are the primary strategies for reducing injuries.

The following two categories of strategies have been used to reduce unintentional injuries:

Providing education about:

- Firearm safety.
- Protective wear such as bicycle helmets.
- Protective restraints such as child car seats, booster seats, and seat belts.
- Crib safety for infants.
- Common causes of choking and suffocation.
- Common causes of drowning including swimming pools, buckets of water, and bathtubs.
- Home safety precautions such as outlet covers, cabinet locks, stair safety gates, and hot water heater temperature controls.
- Fire prevention and reaction, including fire skills training.
- Safe driving practices for parents and youth.
- Parental supervision and child-proofing environments.
- Signs and symptoms of head injury and appropriate follow up actions.
- Family disaster preparedness.

Enacting and enforcing legislation and regulations to require:

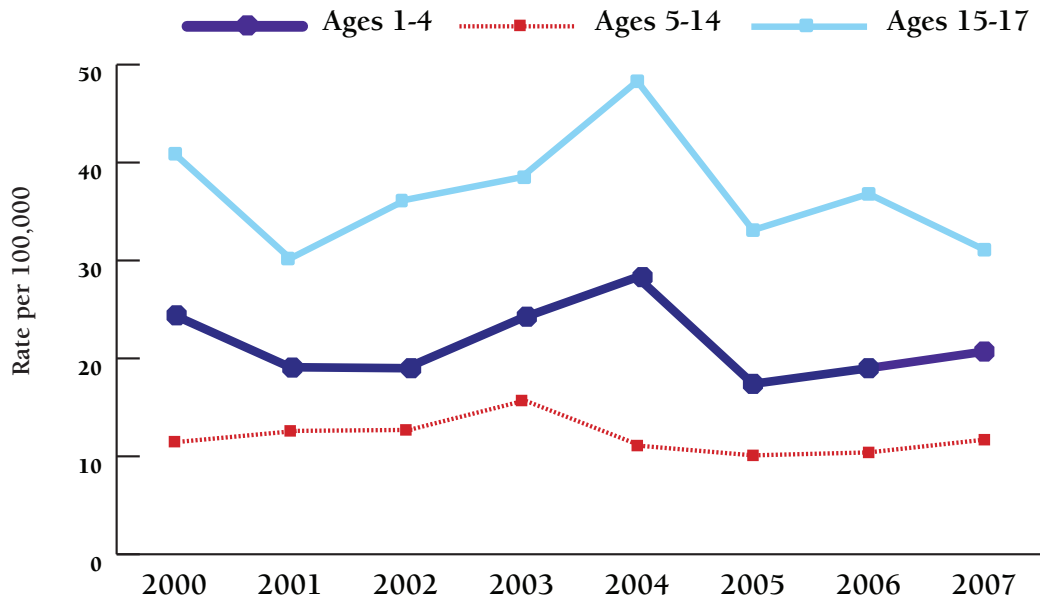
- Smoke detectors, hot water heater temperature controls, and stair safety gates in rental and owned properties.
- Protective restraints such as car seat belts, child safety car seats, and booster seats.
- Pool fencing, self-closing gates, and pool alarms.
- Graduated licensing for teens.
- Toy manufacturer safety standards.
- Use of helmets for all wheeled sport recreation activities (motorized and non-motorized) and horseback riding.

How can we improve the trend in San Diego County?

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with San Diego Safe Kids Coalition, parents and parent associations, schools and school districts, coaches and physical education teachers, local law enforcement, Health and Human Services Agency, landlord associations, and municipalities to:

1. Develop and/or increase enforcement of safety regulations in rental properties (e.g., safety gates, regulating hot water temperature, window safety devices, fences around pools and play areas), existing occupant protection laws (for rental properties), and stronger penalties for violations.
2. Increase enforcement of existing child vehicle restraint laws (e.g., child car seats) and helmet laws requiring that children and adolescents under 18 wear a helmet while riding bicycles, skateboards, scooters, rollerblades, "Heelys," all-terrain vehicles, and horses.
3. Increase education to parents and caregivers regarding home safety precautions such as outlet covers, hot water heater temperature, smoke and carbon monoxide alarms, wall fasteners for tall furniture and televisions, and appropriate child supervision.

Mortality Rate Per 100,000 Children Ages 1-4, 5-14, and 15-17, San Diego County, 2000-2007



The trend is maintaining. The rate of mortality for children ages 1-4 shows variation but no substantial improvement. The rate for children ages 5-14 has not improved since 2000. For those ages 15-17, the rate has returned to 2001 levels.

What strategies can make a difference?

Childhood mortality can be an indicator of risks and conditions such as disease, poor maternal health, adverse living conditions, environmental hazards, lack of access to health services, risky behavior, and other factors. Studies show that communities must develop and implement strategies that are age appropriate and developmentally suitable. Many of the recommended actions throughout this *Report Card* are part of childhood mortality prevention.

The following strategies have been used across the country to reduce childhood mortality:

- Supporting Child Death or Fatality Review Teams to identify risk factors and interventions that could prevent future deaths.
- Conducting community campaigns to reduce factors that place infants, children, and adolescents at risk for premature death.
- Educating parents before they leave the hospital with a newborn about sleeping position (“back to sleep”) to prevent Sudden Infant Death Syndrome (SIDS), and about shaken baby syndrome.
- Providing car and booster seats for infants, toddlers, and young children.
- Educating parents and children about the risks of drowning at home and across the community.
- Promoting gun safety (e.g., safe gun storage or “safe surrender”) programs.
- Implementing suicide awareness and prevention programs.
- Requiring driver safety education programs for teen drivers.

How can we improve the trend in San Diego County?

San Diego was one of the first counties in the state to form a Child Fatality Review Team to study circumstances of deaths and identify opportunities for prevention and intervention. Review teams use case studies of children’s deaths to identify prevention and intervention opportunities. The San Diego County team makes regular public reports with up-to-date recommendations.

Based on what works and what we have been doing, the top three recommendations for San Diego County are to work with San Diego Safe Kids Coalition, San Diego Child Fatality Review Team, HHSA-Office of Violence Prevention, HHSA-Public Health, First 5 San Diego, United Way of San Diego County, parents and parent associations, schools and school districts, community clinics, American Academy of Pediatrics, faith communities, community-based organizations, local law enforcement, HHSA-Child Welfare Services, municipalities, and media partners to:

1. Continue and expand gun safety programs, which protect children at all ages from firearm-related accidental injuries and deaths, suicide, and homicide.
2. Expand campaigns regarding prevention of shaken baby syndrome, Sudden Infant Death Syndrome, drowning, and fatal injuries, particularly in Spanish and other threshold languages.
3. Implement the recommendations of the Child Fatality Review Team and take action to further prevent deaths.

ACKNOWLEDGEMENTS

The Children's Initiative would like to thank all of the individuals who gave of their time, expertise and wisdom in the design, development, and production of this *Report Card*. Without their invaluable guidance and assistance, this project would not have been possible.

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National Center for Health Statistics, Centers for Disease Control and Prevention. Births: Final Data for 2006. *National Vital Statistics Reports*. January 7, 2009; 57(7).

National Center for Health Statistics, Centers for Disease Control and Prevention, Births: Preliminary Data for 2007. *National Vital Statistics Reports*. March 18, 2009; 57(12).

Ages 3 to 6 (Preschool)

Immunization

San Diego Immunization Partnership. Public Health Services, County of San Diego Health and Human Services Agency.

National Immunization Survey, Centers for Disease Control and Prevention.
<http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis>

National objective is from Healthy People 2010, U.S. Department of Health and Human Services.
<http://www.healthypeople.gov/LHI/>

Early Care and Education

California Child Care Resource and Referral Network. *2007 Child Care Portfolio*.
<http://rrnetwork.org/our-research/child-care-portfolio.html>

U.S. Census Bureau, 2005 American Community Survey, Table S1401.
http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=

Ages 6 to 12 (School Age)

Oral Health

California Health Interview Survey (CHIS), University of California, Los Angeles (UCLA) Center for Health Policy Research. <http://www.chis.ucla.edu/>

School Attendance

Data provided for this *Report Card* by San Diego County school districts. These data represent 97% of county student population.

School Achievement (Grade 3)

California Standardized Testing and Reporting Program, as reported by the California Department of Education, Standards and Assessment Division on the DataQuest website. <http://data1.cde.ca.gov/dataquest/>

Obesity

California Fitness Test, as reported by the California Department of Education, Standards and Assessment Division on the DataQuest website. <http://data1.cde.ca.gov/dataquest/>

National objective is from Healthy People 2010, U.S. Department of Health and Human Services.
<http://www.healthypeople.gov/LHI/>

Ages 13 to 18 (Adolescent)

School Attendance

Data provided for this *Report Card* by San Diego County school districts. These data represent 97% of county student population.

School Achievement (Grades 8 and 11)

California Standardized Testing and Reporting Program, as reported by the California Department of

Education, Standards and Assessment Division on the DataQuest website. <http://data1.cde.ca.gov/dataquest/>

Substance Abuse

California Healthy Kids Survey, WestEd, prepared by San Diego County Office of Education, Safe Schools Unit.

Centers for Disease Control and Prevention. U.S. Data: Youth Risk Behavior Surveillance Survey, United States, 2007. *Morbidity and Mortality Report*. June 6, 2008; 57(SS04):1-131.

Youth Suicide

California Healthy Kids Survey, WestEd, prepared by San Diego County Office of Education, Safe Schools Unit. Data from the 8 (out of 18) unified and high school districts that administer Custom Module C (which contains questions related to suicide) as part of their annual survey.

Centers for Disease Control and Prevention. U.S. Data: Youth Risk Behavior Surveillance Survey, United States, 2007. *Morbidity and Mortality Report*. June 6, 2008; 57(SS04):1-131.

Juvenile Arrests

State Department of Justice, Criminal Justice Statistics Center, SANDAG Annual Arrest Reports 2000 through 2006.

http://www.sandag.org/uploads/publicationid/publicationid_1273_6237.pdf

http://sandiegohealth.org/sandag/publicationid_1176_4765.pdf

http://www.sandag.org/uploads/publicationid/publicationid_1336_7392.pdf

California Department of Justice, Criminal Justice Statistics Center. Crime in California Advance Release Report 2008. <http://www.ag.ca.gov/cjsc/publications/advrelease/ad/ad08/ad08.pdf>

Juvenile Probation

San Diego County Probation Department Research Unit. Data specially prepared for this *Report Card*.

Youth Driving Under the Influence

California Department of Motor Vehicles, Research Unit; 2006, 2007 Annual Report of the California DUI management Information System

http://www.ots.ca.gov/pdf/Publications/DMV_DUI_MIS_Report_2007.pdf

Motor Vehicle Crashes Involving Youth DUI

County of San Diego Emergency Medical Services, Epidemiology, SWITRS Database. Data specially prepared for this *Report Card*.

Cross Age: Community and Family

Poverty

U.S. Census Bureau, Small Area Income and Poverty Estimate, years 2000-2007.

<http://www.census.gov/hhes/www/saipe/>

Food Stamps:

Health and Human Services Agency, CalWIN program.

Food Research and Action Center. *SNAP Access in Urban America: A City-by-City Snapshot*. Washington, DC:

Food Research and Action Center. September 2009.

<http://www.frac.org/pdf/urbanfoodstamps09.pdf>

Health Coverage

California Health Interview Survey (CHIS), University of California, Los Angeles (UCLA) Center for Health Policy Research.
<http://www.chis.ucla.edu/>

DeNavas-Walt C et al. *Income, Poverty and Health Insurance Coverage in the United States: 2007*
Current Population Reports - Consumer Income. U.S. Department of Commerce, Economics and Statistics Administration. U.S. Bureau of the Census. August 2008.
<http://www.census.gov/prod/2008pubs/p60-235.pdf>

Domestic Violence

Automated Regional Justice Information System (ARJIS), SANDAG. Data specially prepared for this Report Card.

Child Abuse and Neglect

County of San Diego Health and Human Services Agency, Child Welfare Services Data & Quality Assurance Unit. University of California at Berkeley Center for Social Services, Child Welfare Services/Case Management System. Regional data provided by County of San Diego Child Welfare Services Data Unit.
http://cssr.berkeley.edu/ucb_childwelfare/
<http://cssr.berkeley.edu/CWSCMSreports/referrals/rates.asp>

Violent Crime Victimization of Children

Automated Regional Justice Information System (ARJIS), SANDAG. Data specially prepared for this Report Card.

Unintentional Injury Hospitalizations and Deaths

California Department of Health Services, EPICenter website:
<http://www.applications.dhs.ca.gov/epicdata/default.htm>

Population data from California Department of Finance demographic unit. Prepared by County of San Diego Emergency Medical Services, Epidemiology.

Child Mortality

California Department of Health Services, Center for Health Statistics Vital Statistics Query System. Death records for years 2000 to 2007. <http://www.applications.dhs.ca.gov/vsq/default.asp>

SANDAG January 1 Population Estimates. Prepared by Community Epidemiology, Health & Human Services Agency, County of San Diego.

California Department of Public Health, Birth and Death Records. <http://www.cdph.ca.gov/data/statistics/Documents/VSC-2005-0405.xls>

National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Preliminary Data for 2007 *National Vital Statistics Reports*. August 19, 2009; 58(1).

National Center for Health Statistics, Centers for Disease Control and Prevention. Deaths: Final Data for 2006. *National Vital Statistics Reports*. 2009; 57(14):1-134.

National objective is from Healthy People 2010, U.S. Department of Health and Human Services.
<http://www.healthypeople.gov/LHI/>



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